NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

THURSDAY, NOVEMBER 5, 2020
2:00 P.M.

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

REVISED

BOARD OF DIRECTORS

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

Supervisor Doug Chaffee, Alternate

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

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

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

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

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

1) **Listen to the live audio at +1 (631) 992-3221 Access Code: 774-030-678 or**
2) **Participate via Webinar at https://attendee.gotowebinar.com/register/5267566005606115596 rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
None.

MANAGEMENT REPORTS
1. Chief Executive Officer Report
   a. Department of Health Care Services Quality Award
   b. New Executive Director, Public Affairs
   c. COVID-19 Update
   d. Homeless Health Initiatives Summary
   e. Network Certification and Medical Audit
   f. Medi-Cal Rx Transition
   g. Advisory Committee Joint Meeting
   h. Employee Engagement Efforts
   i. Community Outreach on Mental Health, Scholarship Contest

2. COVID-19 Update

3. Election 2020 Review and Federal Policy Outlook

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

5. Consider Authorizing and Directing Execution of a New Agreement with the California Department of Health Care Services for the CalOptima Program of All-Inclusive Care for the Elderly

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

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

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

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

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

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

REPORTS

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

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

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

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

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

17. Consider Approval of Executive Employment Agreement Terms and Authorization of Execution of Executive Employment Agreement/Employment Agreement Amendment (Chief Executive Officer) *(to follow Closed Session)*

ADVISORY COMMITTEE UPDATES

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

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

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

CS-2 Pursuant to Government Code section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer)

CS-3 Pursuant to Government Code section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS
Agency Designated Representatives: (Andrew Do, Chair; Isabel Becerra, Vice Chair)
Unrepresented Employee: (Chief Executive Officer)

ADJOURNMENT

How to Join Webinar

1. **Please register for Regular Meeting of the CalOptima Board of Directors on November 5, 2020 2:00 PM PDT at:**
   https://attendee.gotowebinar.com/register/5267566005606115596

2. After registering, you will **receive a confirmation email containing a link to join** the webinar at the specified time and date.
   Note: This link should not be shared with others; it is unique to you.
   Before joining, be sure to check system requirements to avoid any connection issues.

3. **Choose** one of the following **audio options:**
   TO USE YOUR COMPUTER'S AUDIO:
   When the webinar begins, you will be connected to audio using your computer's microphone and speakers (VoIP). A headset is recommended.
   --OR--
   TO USE YOUR TELEPHONE:
   If you prefer to use your phone, you must select "Use Telephone" after joining the webinar and call in using the numbers below.
   United States: 1 (631) 992-3221
   Access Code: 774-030-678
   Audio PIN: Shown after joining the webinar

MEMORANDUM

DATE:	October 28, 2020
TO:	CalOptima Board of Directors
FROM:	Richard Sanchez, Interim CEO
SUBJECT:	CEO Report — November 5, 2020, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

Regulator Honors CalOptima as the Only Medi-Cal Plan to Meet Quality Benchmark
On October 8, the Department of Health Care Services (DHCS) honored CalOptima for outstanding performance on 40 quality measures in the Managed Care Accountability Set (MCAS). CalOptima was awarded for being the only Medi-Cal plan in the state to perform above the 50th percentile benchmark in all the quality measures for Reporting Year 2020, which tracks activity in Calendar Year 2019. MCAS comprises quality measures that the state has chosen to assess overall performance in many areas, such as well-child visits, immunizations, cancer screenings, medication management and more. CalOptima shared the news with health networks and providers, who are our partners in the effort to deliver quality care, as well as community stakeholders and employees. We are proud to say that CalOptima is the No. 1 quality Medi-Cal plan, according to state regulators.

CalOptima to Welcome New Executive Director, Public Affairs in November
On November 23, Rachel Selleck will join CalOptima as Executive Director, Public Affairs (Chief of Staff), a role that has been vacant for two years. Rachel has a master's degree in public policy from Pepperdine University and a bachelor's degree in political science from UC Berkeley. Most recently, she worked as chief of staff/public affairs manager at the Orange County Health Care Agency. Prior to that, she held a public affairs specialist role at John Wayne Airport and an account executive position for O'Rorke Public Relations & Advertising Agency, which works solely with government agencies. At CalOptima, Rachel will report directly to me and be responsible for the Communications, Public Policy and Strategic Development departments. I look forward to introducing her at the December 3 Board meeting.

COVID-19 Emergency Extended Until January 2021, Regulator Boosts Provider Funding
As of October 27, Orange County remains the Red Tier (Substantial Risk) of California's Blueprint for a Safer Economy, primarily based on higher testing positivity rates in certain lower-income areas, according to County reports. From CalOptima's first case until October 27, CalOptima has reported 3,325 positive cases, 1,916 hospitalizations and 334 deaths.

- On October 2, the U.S. Department of Health and Human Services (HHS) renewed the COVID-19 public health emergency with a full 90-day extension through January 21, 2021.
- HHS announced that it is providing $20 billion in new provider relief funding. The funding is available for providers who have already received payments due to hardships experienced from COVID-19, previously ineligible providers and an expanded group of behavioral health providers. Providers can apply for the Phase 3 General Distribution payments through

Back to Agenda

November 6. CalOptima shared news about this opportunity with the provider community. Information is available on the HHS website.

Homeless Health Initiatives Summarized Considering COVID-19

During 2019, many organizations, including CalOptima, responded to Orange County's homeless crisis. On April 4, 2019, the Board of Directors committed $100 million for Homeless Health Initiatives. On December 5, 2019, the Board also established Guiding Principles to refine decision making, ensure investment in the most appropriate programs and respond to provider concerns. The summary document that follows my report provides an update about CalOptima's progress and response considering COVID-19. The pandemic creates considerable uncertainty in the health care environment and in the needs of individuals experiencing homelessness. Several initiatives are expected to terminate on December 31, 2020. As a result, CalOptima anticipates requesting Board authority to extend initiatives and/or agreements to allow time to assess COVID-19 impacts and determine ongoing needs, for example, related to the Clinical Field Team and Whole-Person Care pilots.

Regulator Adjusts Timing for Network Certification, Medical Audit

The state announced the status of CalOptima's 2020 annual network certification and took additional actions that will impact CalOptima's certification and medical audit in the future.

- Annual Network Certification: DHCS notified CalOptima that our 2020 Annual Network Certification process is complete with no deficiencies. This is significant because it means CalOptima, in aggregate, has demonstrated access to required care for members. We have expressed appreciation to staff who worked on the certification and to health networks for their partnership. However, the process for network certification is changing whereby DHCS is increasing requirements for delegated health networks. Individual health networks must meet all standards for number and mix of primary and specialty providers, time and distance, service availability, physical accessibility and more, rather than CalOptima in aggregate. DHCS has announced a one-year delay in implementation until July 2022, which will provide more time for staff to work through operational challenges and more time for health networks to prepare.
- Annual Medical Audit: Due to the ongoing public health emergency, DHCS will not be conducting the annual medical audit of CalOptima's Medi-Cal program in 2021. Instead, the state will resume its audit cycle in 2022, most likely in February or March. At that time, DHCS will use a two-year lookback period rather than the customary one-year lookback period. Internal and external stakeholders must still comply with requirements in the 2021 audit protocols because that period will be audited.

Medi-Cal Rx Transition Approaching, Magellan Readies Its Call Center

The Medi-Cal Rx Advisory Workgroup met October 22, and CalOptima staff attended to ensure the latest understanding of all transition details. The topics covered included a general project update, review of policies and processes, details about the contract drug list and additions to the formulary, system testing overview, complaints and grievances policy changes based on stakeholder feedback, All-Plan Letter status, and discussion of the beneficiary notices and scripts. Medi-Cal Rx contractor Magellan reported that it is hiring 330 staff for the customer service call center and will support 17 threshold languages. The call center is not open until January 1, so in the interim, beneficiaries are instructed to call Medi-Cal or their health plan.

Back to Agenda

CalOptima has begun to field some calls from members with questions based on the first notice they received in October, and we are following the state's script with our responses.

Advisory Committees Come Together for Joint Meeting

CalOptima's four advisory committees (Member Advisory Committee, Provider Advisory Committee, OneCare Connect Member Advisory Committee and Whole-Child Model Family Advisory Committee) came together October 8 in a joint meeting to discuss topics of shared interest. To recognize CalOptima's 25th anniversary, Chief Operating Officer Ladan Khamseh and I kicked off the meeting with a brief expression of gratitude to the committees for their support. The meeting continued with three robust presentations:

- Marshall Moncrief, CEO of Mind OC, provided a status report about the Be Well OC facilities and the movement to build a comprehensive, coordinated mental health system for Orange County. Committee members were interested in this effort and its potential impact.
- Deputy Chief Medical Officer Emily Fonda, M.D., shared an overview of the upcoming transition to Medi-Cal Rx. Participants asked numerous questions and expressed concerns.
- Erin Rueff, O.D., Ph.D., chief of Stein Family Cornea & Contact Lens Services at Ketchum Health, spoke about pediatric eye health and preventing myopia (nearsightedness), with special consideration to this time of high computer-screen usage.

Employees Connect and Learn During Multiple Engagement Efforts

October featured a high level of employee engagement through webinars and recognition weeks. Below is a summary of four events:

- All Hands: CalOptima held our quarterly All Hands meeting virtually on October 22. More than 900 attended the live webinar, and others chose to access a recording later. COO Ladan Khamseh and I continued CalOptima's 25th anniversary celebration by highlighting our major milestones. PACE Director Elizabeth Lee showed fun photos from the PACE 7th anniversary drive-thru event. Betsy Ha, Executive Director of Quality & Population Health Management, and Marie Jeannis, Director of Enterprise Analytics, presented some new research into health disparities within CalOptima's ethnic populations. This data will be shared with your Board's Quality Assurance Committee in December.
- Customer Service Week: Continuing a longstanding tradition in a new way, CalOptima recognized Customer Service Week October 5–8 with virtual events, including a word search contest, webinar on teamwork and "Share a Smile" emails sent among co-workers. Customer Service Week honors the work that employees do with members and external partners as well as internal colleagues.
- Healthcare Quality Week: From October 19–21, CalOptima joined the national celebration of quality. Our theme was Equality, Equity and Justice, and via email messages, leaders aimed to educate staff about the emerging issues surrounding health disparities and their impact on overall health care quality.
- Cybersecurity Awareness Month: CalOptima's Information Services team led the agency's participation in National Cybersecurity Awareness Month. Events included weekly informational emails and quizzes about key security topics. External guest speakers also presented three separate lunchtime webinars throughout the month on securing devices at home and at work, securing internet-connected devices in health care, and the future of connected devices.

Back to Agenda

CalOptima Community Outreach Focuses on Mental Health, Scholarship Opportunity
True to our roots as a local health plan, CalOptima continually strives to connect with community members and add value with support. Below are two examples:

- Cambodian and Vietnamese Mental Health Panel: On October 22, CalOptima Director and Orange County Health Care Agency Director Clayton Chau, M.D., and Edwin Poon, Ph.D., CalOptima Director of Behavioral Health Services (Integration) participated in a virtual panel presentation on mental health in the Cambodian and Vietnamese communities. They were joined by several other guests at the event, which was jointly sponsored by TimesOC, Viet Rainbow of Orange County and USC Annenberg Center for Health Journalism. They discussed health disparities within the Cambodian and Vietnamese communities, shared mental health resources and emphasized the need for culturally sensitive care.
- Scholarship Essay Contest: For the past five years, employees have voluntarily funded a scholarship essay contest for CalOptima members who are interested in pursuing careers in health care or social services. This year, employees donated enough to offer two $750 scholarships — one for a college-bound high school senior and another for an adult already in college. Entrants write three short essays about how they have benefited from CalOptima's services, how their current studies will help them in the field of health care or social services, and why they are good scholarship candidates. The application is available here, and the deadline is Friday, November 13. We hold the contest in part to nominate our winner for a $5,000 national essay contest by the Association for Community Affiliated Plans.

Back to Agenda

CalOptima is grateful for the support of our Board of Directors, providers, community partners and other stakeholders who have joined us in an effort to improve the health care delivery system for Orange County residents experiencing homelessness. Much has been accomplished and we look forward to continuing our work on this initiative.

This document provides background on our Homeless Health Initiatives, as well as information about specific efforts that have been launched, some changes implemented to address COVID-19 and future plans.

HOMELESS HEALTH INITIATIVES

During 2019, many organizations across Orange County actively responded to the local homeless crisis, and CalOptima continues to participate by making improvements to the health care delivery system for individuals experiencing homelessness and strengthening services through our Homeless Health Initiatives (HHI). During the COVID-19 pandemic, CalOptima's commitment has not waned and we have adjusted our initiatives to better meet the needs of these individuals. Below is a summary of our current HHI initiatives including these adjustments.

The Board of Directors formed a Homeless Health Ad Hoc Committee at the March 7, 2019 meeting. The committee met regularly, often including homeless advocates and key community representatives. The committee considered opportunities to enhance CalOptima's delivery system to better meet the health care needs of individuals experiencing homelessness, by providing on-site medical care, where the individuals are located. Through the committee's guidance and recommendations to the Board, and with the Board's approval, CalOptima has made great strides in supporting our members experiencing homelessness.

On April 4, 2019, the Board committed $100 million for homeless health initiatives. A total of approximately $43 million has been allocated by the Board for the following specified initiatives.

HHI Projects/Initiatives (as of 6/30/2020)	Funding
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	$11.4 million
Recuperative Care	$8.25 million
Medical Respite	$.25 million
Housing Supportive Services	$2.5 million
Clinical Field Team Start-Up Funds	$1.6 million
CalOptima Homeless Response Team ($1.2 million/year x 5 years)	$6 million
Homeless Coordination at Hospitals ($2 million/year x 5 years)	$10 million
CalOptima Day and QI Program (Homeless Clinic Access Program or HCAP)	$1.2 million*
FQHC (Community Health Center) Expansion and HHI Support	$.6 million*

HCAP Expansion for Telehealth and On Call Days	$1 million
New projects and initiatives with subsequent development of programs that meet CalOptima's Guiding Principles addressing the four categories listed below	$57.1 million*
	$100 million

*Rounded

CalOptima continued to consider program options, in part, by welcoming input from community organizations and providers serving homeless individuals. On June 27, 2019, at a special Board meeting, the Board approved additional allocations for new homeless health initiatives in the following areas:

1. Clinic health care services in all homeless shelters - $10 million
2. Authorize mobile health team to respond to all providers - $10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue - $20 million

The Board recognized that the approved funding allocations allow room for interpretation and the possibility of executing new initiatives in various ways. Further, a state proposal, known as Medi-Cal Healthier California for All (CalAIM), suggested significant changes to the Medi-Cal managed care landscape. While the 2021 starting dates for most CalAIM proposals have been postponed due to COVID-19 pandemic, the state has expressed commitment to this strategy. Although the proposal is not finalized and start dates are unknown, some tenets of CalAIM are designed to enhance services for high-needs populations, including individuals experiencing homelessness.

Guiding Principles

To move forward with effective funding allocations in this dynamic environment, the Board and staff developed four guiding principles to refine decision making, ensure investment in the most appropriate programs and respond to provider concerns. On December 5, 2019, the Board approved the Homeless Health Initiatives Guiding Principles.

Transparent and Inclusive

CalOptima shall foster transparency in homeless health spending by regularly engaging stakeholders to gather ideas and feedback.

Compliant and Sustainable

CalOptima shall spend the $60 million on allowable uses of Medicaid funds only, such as Medi-Cal-covered services for Medi-Cal members.

Strategic and Integrated

CalOptima shall support programs that honor the unique needs of the homeless population while integrating into the existing delivery system.

Defined and Accountable

CalOptima shall identify measures of success and develop incentives to boost accountability in any new homeless health initiative.

Proposals consistent with the principles would be brought forward for consideration by the Board; proposals that are inconsistent would face revision or rejection. Proposals and established initiatives may also change depending on the status of CalAIM. Internal and external audiences can use the principles to

support initiatives that unify the community around our shared goal of better serving Orange County's homeless population, though the Board has full discretion whether to approve a proposed initiative.

Impact of COVID-19

The effects of the COVID-19 pandemic are being felt throughout Orange County. CalOptima has taken action across many fronts to provide a comprehensive and flexible response to address the needs of members (including those experiencing homelessness), providers, stakeholders and employees. As part of this, and with stakeholder input, CalOptima has enhanced existing and proposed HHI initiatives. Some of those enhancements are noted below.

Current Projects and Initiatives

Be Well OC Regional Mental Health and Wellness Campus

Offering a range of services from prevention and early intervention to crisis aversion, acute care and recovery

The Be Well movement joins public, private, academic and faith-based organizations to create a coordinated system of mental health care and support for all Orange County residents. In 2018, stakeholders came together to envision the first Be Well campus. The 60,000-square-foot facility in Orange will offer best-in-class mental health and substance use disorder (SUD) treatment programs for all residents. Services will include triage, psychiatric intake and referral, SUD intake and referral, withdrawal management, transitional residential, residential treatment, and an integrated support center.

In addition to CalOptima, key funding participants include the County of Orange, Hoag, Providence St. Joseph Health and Kaiser Permanente. Under this initiative, a regional wellness center will serve individuals with mental health needs regardless of payor source. Completion of the first hub is targeted for the end of 2020, with services beginning shortly thereafter, including resources available to support individuals with housing needs. Plans for a second wellness center are in development.

The Be Well OC initiative integrates across silos to address social determinants of health and recognizes that issues related to the justice system and housing have a significant impact on health and must be considered as part of a comprehensive solution. This mirrors concerns and priorities highlighted by the state and federal government. CalOptima is an active partner in the broader Be Well initiative, leading and participating in collaborative meetings.

Recuperative Care (including Whole Person Care (WPC) and Medical Respite Care)

Beyond the hospital discharge

The WPC program is a County-led pilot focused on improving coordination of physical, behavioral health and social services for Orange County Medi-Cal members experiencing homelessness. WPC brings together CalOptima, Orange County Health Care Agency (OC HCA) Behavioral Health Services and Public Health Services, hospital emergency rooms, community health centers, and other homeless service providers.

WPC Recuperative Care provides up to a 90-day stay in a clean, safe environment for CalOptima members who are experiencing homelessness to recover from physical illness or injury when they do not meet the medical necessity criteria for inpatient or nursing facility care. For example, recuperative care may be part of a hospital discharge plan for a member experiencing homelessness who needs follow-up care, such as wound care. During their recuperative care stay, members will have access to housing navigation and, through CalOptima, health care services. CalOptima and the WPC program share the cost paid to the recuperative care facility.

The WPC pilot portion of the Department of Health Care Services (DHCS) Medi-Cal 2020 Waiver is currently scheduled to expire on December 31, 2020. DHCS has submitted a request to the Centers of Medicare and Medicaid Services (CMS) to extend the WPC pilot through 2021. CalOptima is currently working with OC HCA on strategies to continue recuperative care beyond the current 2020 end date. We anticipate asking our Board for approval for any changes needed to continue supporting recuperative care and the WPC program wind down activities following termination and, as needed, if CMS and DHCS approve an extension.

CalOptima also made a grant to the County for Medical Respite care for members who are expected to require more than the 90 days of recuperative care allowed under WPC, remain homeless, and need a stable environment to achieve and maintain medical stability, yet do not meet criteria for a hospital or nursing facility stay. This program is available to members who are certified for hospice, need intravenous chemotherapy or have other serious conditions and meet other specified criteria. The Medical Respite grant provides up to an additional 90 days in a recuperative care facility, unless more time is approved. OC HCA administers the Med-Cal Respite grant.

Clinical Field Teams (CFT)

On-call mobile medical professionals treating individuals experiencing homelessness where they are

The CFTs launched in April 2019 to provide on-call urgent care service and travel throughout the community to where the individuals experiencing homelessness are located. The CFTs treat individuals by providing urgent care, such as wound care, prescriptions and immediate dispensing of commonly used medications. While treating the individual, the CFTs can also provide other services, such as health screenings. They are on call from 8:30 a.m. to 4:30 p.m., seven days a week. They also provide regularly scheduled hours at shelters and other hot spots (locations in the community where individuals experiencing homelessness gather). CalOptima reimburses claims for services to members under this initiative regardless of the member's health network or primary care provider assignment.

CFTs are operated by participating community health centers that serve individuals experiencing homelessness, both uninsured and those who have Medi-Cal coverage. A CFT typically consists of three individuals, a physician or physician assistant, a medical assistant and a care coordinator.

To deploy a CFT, a CalOptima partner organization calls the CalOptima Homeless Response Team (HRT) designated phone line between 8:30 a.m. and 4:30 p.m. and provides information about the person and their urgent care needs. The HRT then contacts the CFT for rapid response. As initially designed, following dispatch, the CFT will meet the individual where they are, such as a park or shelter, to address the urgent need, assess for chronic conditions, prescribe necessary medication, and support referrals for other services. As a result of COVID-19, the CFTs may also address the urgent care needs through telehealth services, when appropriate.

Additionally, prior to COVID-19, a CalOptima Personal Care Coordinator (PCC) would be dispatched, based on availability, to assist the CFT and referring agency to coordinate care for a CalOptima member (such as making referrals, coordinating and providing assistance in navigation of services, etc.). Information about the CFT visit is also shared with the member's assigned health network for ongoing care coordination. If the person is not a member, the referring agency handles follow-up. As a result of COVID-19, PCCs are continuing to coordinate and support member needs virtually.

These program changes, providing CFT and PCC support virtually, were adopted to reduce the potential risks to individuals receiving services, as well as risks to CFT, referring agency and CalOptima staff. Virtual care also supports continued access to services at locations that might otherwise be difficult to access, such as closed campus shelters, and it increases capacity.

From April 2019 through June 2020, of the nearly 690 visits through the CFT program; 64% were for CalOptima members. Common conditions reported include skin conditions (such as abscesses,

infections, dog and bug bites), swelling of extremities and face, flu-like symptoms and medication refills. Nearly 140 referrals were made to recuperative care.

This pilot program currently has an end date of December 31, 2020. Staff is developing options to make this an ongoing, sustainable program. CalOptima is aware of the dramatic changes throughout the county, such as expansion of shelter options through Project Roomkey, including health care delivery at those sites, and expansion of telehealth. There is a great deal of uncertainty as we navigate the COVID-19 pandemic. As we consider the implications of the "new normal" and develop the sustainable program to meet the ongoing needs of our members experiencing homelessness, we anticipate asking our Board to extend the CFT pilot.

CalOptima Homeless Response Team (HRT)

Connecting the CFTs with individuals in need of medical attention

This vital team of CalOptima staff serves as liaisons with the homeless population by making regular field visits to shelters, hot spots and recuperative care facilties. Special population PCCs on the HRT also visit these locations to provide assistance to CalOptima members. For example, they provide ID cards, process member requests to change their primary care provider or health network, and arrange transportation for medical appointments.

This team also serves as the primary point of contact at CalOptima for coordinating care with collaborating partners, such as community health centers, OC HCA's Outreach & Engagement staff and CHAT-H nurses, homeless shelter operators and Homeless Emergency Aid Programs (HEAP) providers.

Staff also regularly participates in collaborative meetings including:

- Anaheim Homeless Collaborative
- Collaborative to Assist Motel Families
- Meetings for Central and South Service Plan Areas
- WPC Core Care Coordination Workgroup
- WPC Collaborative

During the past year, CalOptima increased our involvement in the community through the HRT. Activities as of June 2020 include:

- Receipt of 476 referrals from the Case Management department for outreach
- 1,505 face-to-face contacts with individuals experiencing homelessness (pre-COVID-19)
- Participation in five pre-enforcement engagements in Anaheim, Costa Mesa, Fullerton, Placentia and San Clemente
- 786 dispatches for CFT on-call visits

In addition, prior to COVID-19, the HRT:

- Spent an average of 50% of the work week in the field at shelters, encampments, parks, recuperative care sites and other hot spots
- Had weekly scheduled hours at Courtyard, La Mesa and Bridges and had been working to establish scheduled hours at Fullerton Armory, The Link, and Friendship Shelter

As noted above, the HRT provides virtual coordination services and outreach at this time.

Homeless Coordination at Hospitals

Homeless-specific discharge planning and coordination

This program helps hospitals meet California's SB 1152 requirements for specific discharge planning and care coordination for individuals experiencing homelessness. The law went into effect on July 1, 2019. The hospitals are required to develop discharge plans for patients, including coordinating services and making referrals to other agencies for behavioral health, health care and social services to prepare the patients to return to the community.

CalOptima is providing financial support to contracted hospitals in Orange County to develop and implement these requirements, including use of data-sharing technology to help facilitate coordination of services for individuals experiencing homelessness with other providers and community partners. This support is through a 2% increase in Medi-Cal Classic rates paid to Medi-Cal-contracted acute care hospitals. The funding is distributed based on volume of services provided to members.

Homeless Clinical Access Program (HCAP) and Community Health Center Homeless Services Expansion

Integrated, well-coordinated care and improved access

HCAP focuses on increasing access to care for individuals experiencing homelessness by providing incentives for community health centers to establish regular hours at Orange County shelters and hotspots. The expanded access to primary and preventative care services and care coordination helps connect the member back to the primary care delivery system. CFTs and other community health centers that meet program requirements may receive an incentive based on scheduled time and members served through mobile or on-site fixed clinics. CFT on-call access has been added to the HCAP program for on-call services. Additionally, telehealth visits are now included in this incentive program.

Similar to the CFT program, CalOptima will also reimburse community health center claims for services to members seen at the shelters and hotspots through this initiative regardless of member's health network or primary care provider assignment.

HCAP has seven community health centers contracted to provide services at shelters and hotspots under the CFT and expansion initiatives. To date, we have received submission under the HCAP incentive for scheduled days at over 10 shelters or designated hotspots. Since the program started in August 2019, HCAP has supported approximately 1,500 hours in the field providing services to 1,200 individuals (including CalOptima and non-CalOptima members) experiencing homelessness. While the Courtyard, Fullerton Armory, and Salvation Army are visited most frequently by HCAP participating community health centers, other locations, such as Friendship Shelter in South County, have been supported as well. There are plans to expand HCAP services to other locations throughout the county.

New Projects and Initiatives in Development

Housing Supportive Services and Project Homekey

Collaborating with OC HCA

The OC HCA provides housing supportive services through various programs, such as WPC. CalOptima also provides housing supportive services for members enrolled in its Health Homes Program (HHP). CalOptima is collaborating with OC HCA to reimburse WPC for housing supportive services for members enrolled in both HHP and WPC.

In November 2019, the OC HCA established a funding pool to provide these services to individuals not receiving them through other programs, such as WPC. In order to support these efforts, CalOptima's Board approved use of Intergovernmental Transfer (IGT) funds to reimburse OC HCA for housing supportive services for members needing these services that are not funded through other programs, such as HHP and WPC (e.g., when WPC funding is exhausted). As a result of the COVID-19 pandemic, OC HCA has implemented a variety of strategies including Project Roomkey to provide short-term

shelter for social distancing for high-risk individuals (e.g. those 65 years and older or experiencing serious health conditions). As Project Roomkey winds down, OC HCA is now focusing on the Homekey Program that would provide interim housing and wraparound services for former Roomkey participants and others experiencing homelessness impacted by COVID-19. OC HCA has asked that IGT funds be reallocated to the Homekey Program from the housing supportive services not funded through HHP and WPC. CalOptima and OC HCA are working together to explore the Project Homekey opportunity.

Transitions of Care Pilot and Incentive

Improving transitions from hospital to skilled nursing to recuperative care

In the summer of 2019, CalOptima convened a workgroup, including representatives from CalOptima, health networks, hospitals and WPC, to consider opportunities to improve coordination and transitions of care for members experiencing homelessness. The workgroup narrowed its focus to transitions from inpatient to skilled nursing facility (SNF) to recuperative care to community. As CalOptima fleshed out final details of a pilot, conducted stakeholder vetting, and was preparing to take the proposal to the Board for consideration, the workgroup continued to meet to discuss opportunities under the proposed CalAIM. Due to COVID-19 and related challenges SNFs face during the pandemic, CalOptima has made the difficult decision to postpone this initiative indefinitely.

Direct Engagement of Members Experiencing Homelessness

Learning from our community partners and those with lived experience

CalOptima met with stakeholders in December 2019 as well as in March, July and September 2020 to solicit input on strategies and best practices to directly engage individuals experiencing homelessness. These stakeholders included chairs from CalOptima's member advisory committees, OC HCA and other organizations providing direct outreach activities to individuals experiencing homelessness. The stakeholders recommended CalOptima hear directly from those who have "lived expertise". Initially, focus groups and/or town halls were under consideration. Due to the current environment, CalOptima and the stakeholder workgroup have begun planning to conduct individual key informant interviews and virtual focus groups to obtain input from those who experienced homelessness in the past and are now housed. Staff anticipates that these interviews will help inform development of a strategy for direct engagement with members currently experiencing homelessness.

Housing for a Healthy California Program (HHCP)

Collaborating with supportive housing grant applicants

CalOptima provided letters of commitment in support of two grant applications under the HHCP to:

- AFH Casa Paloma LP, an affiliate of American Family Housing (AFH), to support its grant application for funding to develop a property, which would include new supportive housing units in Orange County.
- OC HCA to support its application for housing subsidies and rental assistance for existing and new supportive housing in Orange County.

Under the letters of commitment, CalOptima agreed to enter a Memorandum of Understanding (MOU) to support care coordination for residents who are also CalOptima members. Grants under the HHCP would benefit Medi-Cal members who experience chronic homelessness or are high-cost health users and meet other eligibility criteria.

AFH has notified CalOptima that its grant application was approved. It also advised CalOptima that it anticipates developing a total of 69 affordable housing units, of which 48 will be permanent supportive housing (with 34 being funded through the HHCP, an increase over its original submission). We

anticipate asking our Board for approval to issue a new Letter of Commitment to reflect the increase in permanent supportive housing units under HHCP.

CalOptima is meeting regularly with AFH, which will act as the Lead Service Provider for the complex. During these meetings, CalOptima and AFH have been educating each other about their respective programs to provide the baseline for MOU development. Under the MOU, CalOptima would provide covered Medi-Cal services and coordinate care with AFH for CalOptima members residing at the AFH Casa Paloma property. Occupancy is expected to begin in 2022.

A Public Agency

CalOptima

Better. Together.

COVID-19 Update

Board of Directors Meeting

November 5, 2020

David Ramirez, M.D., Chief Medical Officer

Back to Agenda

COVID-19 Impact in Orange County

- Orange County moved into the Red Tier (Tier 2) of the California Department of Public Health (CDPH) framework on September 8.
- Beginning September 22, Orange County schools are eligible to reopen in-person instruction as long as the County data remains consistent with the Red Tier or better.

Back to Agenda

CalOptima
A Public Agency

Federal and State Regulatory Updates

- Federal Public Health Emergency (PHE)
  - PHE extended to January 21, 2021 at the federal level.
- Department of Health Care Services (DHCS) Preventive Care Outreach Call Campaign
  - Phase 1 Guidance (due December 31, 2020)
    - Outreach to infants and toddlers up to age 2 (up to their third birthday) who have not received a checkup or well check visit for preventive care services.
    - Particularly focus on routine immunizations and blood lead level screenings
  - Phase 2 Guidance (due March 31, 2021)
    - Outreach to children ages 3 through 6 years old who have not received a checkup or well check visit for the preventive care services

Back to Agenda

CalOptima
A Public Agency

CalOptima Preventive Care and Immunization Campaign

- Local multilingual program to encourage well visits and immunizations launched September 2.
- All Medi-Cal members will be sent flu vaccine reminder postcards in mid-November.
- CalOptima social media, comprehensive marketing campaign and website content have been updated with flu vaccination campaign messaging.
- Customer service message reminds callers about the need for immunizations.
- Health networks and providers will also be outreaching to members to promote flu vaccination.
- Drive-thru immunization clinic for PACE members.

https://www.caloptima.org/en/Features/Vaccinate.aspx

Back to Agenda

CalOptima
A Public Agency

CalOptima Flu Vaccination Campaign



Back to Agenda

CalOptima
A Public Agency

Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

Back to Agenda

CalOptima
A Public Agency

CalOptima Board of Directors Presentation

Election 2020 Review and Federal Policy Outlook

Akin Gump
STRAUSS HAUER & FELD LLP

November 5, 2020

Josh Teitelbaum, Senior Counsel

Heide Bajnrauh, Senior Policy Advisor

© 2020 Akin Gump Strauss Hauer & Feld LLP
Back to Agenda

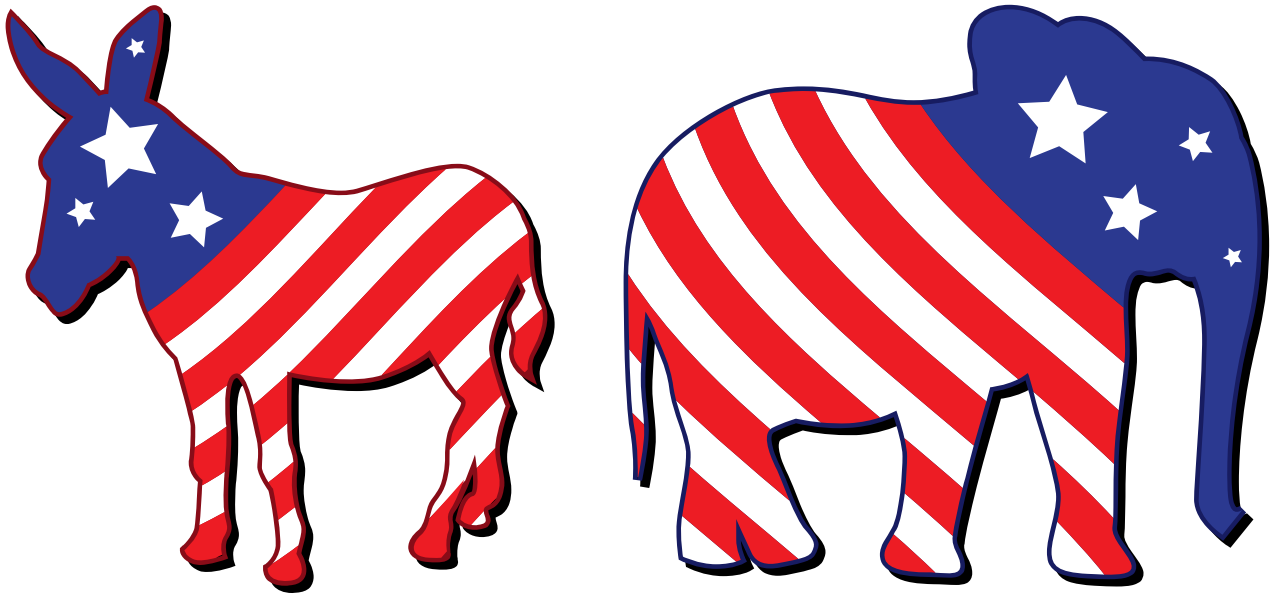
Agenda

- Election 2020 Review
- Lame Duck Activity
- 2021 Policy Outlook
  - 117th Congress
  - Administration

© 2020 Akin Gump Strauss Hauer & Feld LLP
Back to Agenda

2020 General Election Results

- White House
- House
- Senate



© 2020 Akin Gump Strauss Hauer & Feld LLP
Back to Agenda

Lame Duck

- Appropriations
- COVID-19 Relief
- Other Legislation?



© 2020 Akin Gump Strauss Hauer & Feld LLP
Back to Agenda

2021 Outlook

- 117th Congress will be sworn in on January 3
- Public Health Emergency set to expire in late January
- Release of President's FY 2022 Budget Request in February
- Vaccine distribution

© 2020 Akin Gump Strauss Hauer & Feld LLP
Back to Agenda

2021 Outlook

- Future of the Affordable Care Act
  - Possible increase of the use of CMMI authority
  - State Innovation Waivers
- Medicaid Fiscal Accountability Rule
  - Does it make a comeback in a Trump Administration?
- Economic Outlook for Medicaid
  - FMAP increase through public health emergency
  - Increased economic instability as states struggle through the pandemic
- Drug Pricing Issues
- Potential incentives to increase access to the Medicaid Program

© 2020 Akin Gump Strauss Hauer & Feld LLP
Back to Agenda

Questions



Josh Teitelbaum, jteitelbaum@akingump.com

Heide Bajnrauh, hbajnrauh@akingump.com

© 2020 Akin Gump Strauss Hauer & Feld LLP
Back to Agenda

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

October 1, 2020

A Regular Meeting of the CalOptima Board of Directors was held on October 1, 2020, at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act. Chair Andrew Do called the meeting to order at 2:00 p.m. and Director Schoeffel led the Pledge of Allegiance.

ROLL CALL

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

Members Absent: None

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

Chair Do announced that staff was continuing Agenda Item 4., Intergovernmental Transfer Overview for further study.

PRESENTATIONS

Chair Do congratulated CalOptima, noting that today is the 25th Anniversary of the organization. He provided background on CalOptima, noting that it is a public/private partnership, and thanked CalOptima's providers, community partners, and other stakeholders. Chair Do noted that every county, state, and congressional office in Orange County has provided a letter of recognition to commemorate CalOptima's 25th Anniversary. In addition, Chair Do thanked CalOptima employees for their dedication and commitment to ensuring that members have access to quality health care delivered in a cost effective and compassionate manner, and presented a resolution on behalf the Orange County Board of Supervisors.

Interim Chief Executive Officer Richard Sanchez and Ladan Khamseh, Chief Operating Officer, reviewed a timeline of CalOptima's history.

Back to Agenda

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Mr. Sanchez highlighted several items from his report including Intergovernmental Transfer (IGT) 10 funds, an All-Plan Department of Health Care Services (DHCS) Medi-Cal meeting, and the withdrawal of the Medicaid Fiscal Accountability Rule (MFAR). With regard to IGT 10 funds, he informed the Board that the anticipated rate cuts to the Medi-Cal Expansion program will not be as deep as originally anticipated, and that staff would share more details as they become available. With regard to the MFAR, the Centers for Medicare & Medicaid Services (CMS) has withdrawn its proposal, which would have negatively impacted health plans financially nationwide. Mr. Sanchez also noted that the Strategic Plan Update is on the agenda and that the current plan revolves around five pillars with several overarching goals associated with each pillar.

The Board directed staff to provide additional details on how the current strategic plan is being operationalized and to convene a Strategic Plan Workshop for the Board to provide input and direction on the Strategic Plan, including potential updates.

PUBLIC COMMENTS

There were no requests for public comment.

INFORMATION ITEMS

3. COVID-19 Update

David Ramirez, M.D., Chief Medical Officer, provided an update on COVID-19.

Emily Fonda, M.D., Deputy Chief Medical Officer, provided an update on the Orange County Nursing Home COVID-19 Infection Prevention Initiative. Dr. Fonda noted that this comprehensive infection control training program was launched on June 1, 2020 in partnership with UC Irvine and the Orange County Health Care Agency. A parallel program that has been helpful in controlling nursing home infections is the Post-Acute Infection Prevention Quality Initiative (PIPQI), which supports the use of chlorhexidine (CHG) soap in place of regular liquid soap for bathing in nursing homes. The goal of the PIPQI Initiative is to reduce the presence of multidrug resistant organisms, such as MRSA, that are highly prevalent on the skin of nursing home patients. CalOptima recently increased funding and incentives to support the CHG protocol. An added benefit is that coronaviruses, including COVID-19, are highly sensitive to CHG.

Miles Masatsugu, M.D., Medical Director, PACE Program, provided an overview of the impact of COVID-19 on the PACE Program and its participants, including the launch of "PACE Without Walls" initiative.

Brigette Gibb, Executive Director, Human Resources, provided an update on the impacts that COVID-19 has had on the CalOptima work force, including the rapid deployment of temporary telework to ensure that employees remain safe and are still be able to serve the members.

Back to Agenda

2. Medi-Cal Pharmacy Carve Out

Dr. Fonda provided an overview of the Medi-Cal Pharmacy Carve Out program that DHCS is implementing on January 1, 2021. The DHCS has selected Magellan Rx as its Pharmacy Benefit Manager (PBM). She noted that, while CalOptima currently manages and pays for pharmaceuticals for CalOptima Medi-Cal members, this will change at the end of the calendar year. Dr. Fonda also noted that staff has been actively working with providers, members, community-based organizations, associations and the state in an effort to ensure that the transition to the state's PBM for pharmaceutical needs of CalOptima's Medi-Cal members is as smooth as possible. She also noted that many details have not yet been worked out, and that many stakeholders have expressed concerns about this transition and how it will impact members' access to the medications they need.

4. Intergovernmental Transfer Overview

This item was continued for further study.

5. Strategic Plan Update

The Board directed staff to schedule a Strategic Planning Workshop as part of the process of reviewing the current Strategic Plan and receiving input from the Board on any updates that may be appropriate.

6. Overview of Recent Department of Health Care Services Medical Audit Findings

TC Roady, Director, Regulatory Affairs and Compliance, provided an overview of recent Department of Health Care Services (DHCS) Medical Audit findings. He noted that the audit consisted of three scopes: 1) non-seniors and Persons with Disabilities (Non-SPD) Medi-Cal members; 2) SPD Medi-Cal members; and 3) Medicaid-based services in Cal MediConnect. Mr. Roady also noted that there were seven (7) findings in Medi-Cal non-SPD for this audit and reviewed staff's plan for correcting the currents issues as well as on going monitoring.

The Board directed staff to add a quarterly update on audit findings and the status of each until they are closed out.

CONSENT CALENDAR

7. Minutes

a. Approve Minutes of the September 3, 2020 Regular Meeting of the CalOptima Board of Directors

b. Receive and File Minutes of the May 20, 2020 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee: the May 21, 2020 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; and the August 13, 2020 Regular Meeting of the CalOptima Board of Directors' Provided Advisory Committee

8. Consider Reappointment to the CalOptima Board of Directors' Investment Advisory Committee

9. Consider Appointments to the CalOptima Board of Directors' Investment Advisory Committee

10. Consider Appointments of OneCare Connect Member Advisory Committee and Whole-Child Model Family Advisory Committee Chairs and Vice Chairs

Back to Agenda

11. Consider Appointment to the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

12. Receive and File August 2020 Financial Summary

13. Receive and File Compliance Report

14. Receive and File Federal and State Legislative Advocates Reports

15. Receive and File CalOptima Community Outreach and Program Summary

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

REPORTS

16. Consider Accepting and Receiving and Filing Fiscal Year 2019-20 CalOptima Audited Financial Statements

Action: ***On motion of Vice Chair Becerra, seconded and carried, the Board of Directors accepted and received and filed the Fiscal Year (FY) 2019-20 CalOptima consolidated audited financial statements as submitted by independent auditors Moss-Adams, LLP (Motion carried 9-0-0)***

17. Consider Ratification and Authorization of Expenditures Related to the Coronavirus Pandemic

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors ratified and authorized unbudgeted expenditures from existing reserves for emergency purchases related to the coronavirus pandemic not to exceed $137,802. (Motion carried 9-0-0)***

18. Consider Authorization of Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2020-2021 Operating Budget

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 Corwin, seconded and carried, the Board of Directors authorized the reallocation of the following budgeted funds from Medi-Cal: Other Operating Expenses to fund the Informatica Data Masking Software Maintenance license fee through June 30, 2021: 1.) $67,950 from the Cloud Government/Storage Subscription; and 2.) $67,950 from the Computer Equipment. (Motion carried 8-0-0; Director Schoeffel absent)***

Back to Agenda

19. Consider Authorization and Ratification of Budget Reapportionment Changes in the CalOptima Fiscal Year 2020-21 Capital Budget for Various Information Services Capital Projects

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

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors ratified the reapportionment of budgeted funds among capital expense categories for various information services capital projects. (Motion carried 8-0-0; Director Schoeffel absent)***

20. Consider Authorizing Employee and Retiree Group Health Insurance and Wellness Benefits for Calendar Year 2021

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

Action: ***On motion of Vice Chair Becerra, seconded and carried, the Board of Directors: 1) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into contracts and/or amendments to existing contracts, as necessary, to continue to provide group health insurance, including medical, dental, and vision for CalOptima employees and eligible retirees (and their dependents), and basic life, accidental death and dismemberment, short-term disability (STD) and long-term disability (LTD) insurance, an employee assistance program, and flexible spending accounts for Calendar Year (CY) 2021 in an amount not to exceed $23 million which includes the following proposed changes: a.) A decrease in employer contributions (based on the percentage of premium the employer pays for each plan), as a result of a 6.6% reduction in premium rates, reducing costs to CalOptima for CY 2021 in an amount of $1,444,451; b.) The addition of a new option for the Cigna HealthCare (Cigna) HMO medical plan (Select Network) offered alongside the current full network Cigna HMO plan for active employees and eligible retirees with reduced premiums, which could result in an estimated cost savings of as much as $367,464 if employees select this plan over those with more expensive employee contribution rates; c.) An increase in employee contributions at each tier level for the current full network Cigna HMO plan to mirror the same employee contribution schedule as the Kaiser HMO medical plan; and d.) A continuation of employer contributions for CY 2021 in an estimated amount of $182,500 to fund the Health Savings Accounts (HSA) monthly for employees currently enrolled in the Cigna High Deductible Health Plan (HDHP); and 2.) Authorized the acceptance of the premium holiday in the amount of $125,000 received from Cigna Healthcare (Cigna); and 3.) Authorized the receipt and expenditures for CalOptima staff wellness programs from $25,000 in funding received from the Cigna Wellness/Health Improvement Fund for CY 2021. (Motion carried 8-0-0; Director Schoeffel absent)***

Back to Agenda

21. Consider Approval to Redirect Intergovernmental Transfer (IGT) 9 Funds Allocated for Expanded Office Hours to Support Virtual Urgent Care Implementation During Coronavirus (COVID-19) Pandemic and Beyond

After considerable discussion, the Board directed staff to return with a plan for implementing virtual urgent care and approved the item as presented.

Action: ***On motion of Director Giammona, seconded and carried, the Board of Directors approved the redirection of up to $2.0 million of IGT 9 funds originally allocated for the Member Access and Engagement: Expanded Office Hours (Expanded Office Hours) Pilot towards contracting with a 24/7 virtual urgent care vendor for services that will include implementation and rapid deployment support for CalOptima Community Network (CCN) members during and after the COVID-19 pandemic (Motion carried 9-0-0)***

22. Consider Approval of the Calendar Year 2021 Behavioral Health Applied Behavior Analysis Pay for Value Performance Program

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors approved the Behavioral Health Applied Behavior Analysis (ABA) Pay for Value (P4V) Program for the Measurement Period of January 1, 2021 through December 31, 2021. (Motion carried 9-0-0)***

23. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract and Remove the Medi-Cal Line of Business

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

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors, authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's Pharmacy Benefits Manager (PBM) services agreement with MedImpact Healthcare Systems Inc. (MedImpact) to: 1.) Remove the Medi-Cal line of business effective January 1, 2021; and 2.) Extend the contract for provision of services for the OneCare, OneCare Connect and PACE lines of business through December 31, 2024. (Motion carried 8-0-0; Director Schoeffel absent)***

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

This item was continued for further study.

Back to Agenda

25. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Primary Agreement with the California Department of Health Care Services Related to Rate Changes

Action: ***On motion of Vice Chair Becerra, seconded and carried, the Board of Directors authorized and directed the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Agreement between the California Department of Health Care Services (DHCS) and CalOptima related to rate changes. (Motion carried 9-0-0)***

26. Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term

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

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors ratified the amendment to the current Kaiser Foundation Health Plan, Inc. Health Network Contract to extend the current term through the date of the next CalOptima Board meeting, November 5, 2020. (Motion carried 8-0-0; Director Schoeffel absent)***

27. Consider Authorizing Amendments to the OneCare and OneCare Connect Behavioral Health Care Services Contract with the Orange County Health Care Agency

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

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to Amend the Behavioral Health Care Services Contract with the Orange County Health Care Agency (County of Orange) to: 1.) Extend the contract through December 31, 2021; and 2.) Add language incorporating the provision of opioid use disorder treatment into the contract. (Motion carried 8-0-0; Directors Chau and Schoeffel absent)***

28. Consider Approval of Modifications to Quality Improvement Policies

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors approved modifications to the following CalOptima policies pursuant to CalOptima's annual review process: GG.1650: Credentialing and Recredentialing of Practitioners; and GG.1633: Board Certification Requirements for Physicians. (Motion carried 8-0-0; Supervisor Steel absent)***

Back to Agenda

29. Consider Approval of Proposed Revisions to Strategic Development, Community Relations Policy AA.1223: Participation in Community Events by External Entities

Action: ***On motion of Vice Chair Becerra, seconded and carried, the Board of Directors: 1.) Approved proposed revisions to CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities; and 2.) Authorized the Chief Executive Officer to implement the policy with reflected revisions. (Motion carried 8-0-0; Supervisor Steel absent)***

Chair Do announced that Agenda Item 30 would be considered after Closed Session.

ADVISORY COMMITTEE UPDATES

31. Provider Advisory Committee Update

Junie Lazo-Pearson, Ph.D., PAC Chair, provided an update on the activities of the Provider Advisory Committee.

32. OneCare Connect Member Advisory Committee Update

Materials were accepted as presented.

33. Whole-Child Model Family Advisory Committee Update

Kristen Rogers, WCM Chair, provided an update on the activities of the Whole-Child Model Family Advisory Committee.

Chair Do announced he was reordering the agenda to hear Board Member Comments and Board Committee Reports before adjourning to Closed Session

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Board Members congratulated CalOptima on its 25th Anniversary of providing members with access to quality health care services delivered in a cost-effective and compassionate manner.

CLOSED SESSION

The Board of Directors adjourned to closed session at 5:10 p.m. pursuant to Government Code section 54957, PUBLIC EMPLOYEE PERFORMANCE APPOINTMENT (Chief Executive Officer); pursuant to Government Code section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer); and Pursuant to Government Code section 54957.6, CONFERENCE WITH LABOR NEGOTIATIORS Agency Designated Representatives: (Andrew Do, Chair; Isabel Becerra, Vice Chair) Unrepresented Employee: (Chief Executive Officer).

The Board reconvened to open session at 6:14 p.m. and the Clerk re-established a quorum.

Back to Agenda

ROLL CALL

Members Present: Supervisor Andrew Do, Chair; Isabel Becerra, Vice Chair; Jackie Brodsky; Clayton Chau (non-voting); Clayton Corwin; Victor Jordan; Scott Schoeffel; Trieu Tran, M.D.

Members Absent: Mary Giammona, M.D.; Supervisor Michelle Steel

Chair Do announced that no reportable action was taken in Closed Session.

30. Consider Approval of Executive Employment Agreement Terms and Authorization of Execution of Executive Employment Agreement/Employment Agreement Amendment (Chief Executive Officer)
This item was continued to the November 5, 2020 Board meeting.

ADJOURNMENT
Hearing no further business, Chair Do adjourned the meeting at 6:17 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: November 5, 2020

Back to Agenda

MINUTES

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

August 27, 2020

A Regular Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee (OCC MAC) was held via Webinar on August 27, 2020 at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Patty Mouton called the meeting to order at 3:03 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

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

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

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

MINUTES

Approve the Minutes of the June 25, 2020 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC)

Action: ***On motion of Member Sandra Finestone, seconded and carried, the Committee approved the minutes of the June 25, 2020 meeting by a roll call vote. (Motion carried 8-0-0)***

Back to Agenda

PUBLIC COMMENT

There were no requests for public comment

REPORTS

Consider Recommendation of Long-Term Care Candidate

An application was received for the open Long-Term Care Representative seat from Meredith Chillemi. An ad hoc committee made up of Members Josefina Diaz, Sara Lee and Patty Mouton reviewed the application and a subcommittee meeting was held via conference call on August 18, 2020 to review and score the application. After review and discussion, the ad hoc is recommending Meredith Chillemi for the Long-Term Services and Support Representative

Action: ***On motion of Member Gamez, seconded and carried, the Committee approved the recommendation of Meredith Chillemi as the Long-Term Care Representative by roll call vote. (Motion carried 8-0-0)***

Consider Recommendation of OCC MAC Chair and Vice Chair

OCC MAC received a letter of interest from Patty Mouton, Seniors Representative for the Chair position. There were no nominations from the floor, Vice-Chair Corzo requested a motion to recommend Patty Mouton as the OCC MAC Chair for FY 2020-22.

Action: ***On motion of Member Finestone seconded and carried, the Committee approved the recommendation of Patty Mouton for OCC MAC Chair by roll-call vote. (Motion carried 8-0-0)***

OCC MAC also received a letter of interest from current OCC MAC member Keiko Gamez, Member Representative for the Vice Chair position. There were no further nominations from the floor and Vice Chair Corzo asked for a motion to recommend Keiko Gamez as the OCC MAC Vice Chair for 2020-22.

Action: ***On motion of Chair Mouton, seconded and carried, the Committee approved the recommendation Keiko Gamez as the OCC MAC Vice Chair by roll-call vote. (Motion carried 8-0-0)***

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Richard Sanchez, Interim Chief Executive Officer (CEO) provided a verbal update the current status of COVID-19 and the County of Orange. He also spoke on how the Department of Health Care Services (DHCS) Medi-Cal expansion rate reductions which will be implemented on January 1, 2021. He noted that more information will be forthcoming from DHCS and that he would keep the OCC MAC updated. Mr. Sanchez also discussed the plans for the Pharmacy Carve-Out which will be discussed with the new Board at their September meeting.

Back to Agenda

Chief Operating Officer Update
Ladan Khamseh, Chief Operating Officer provided an update on the Qualified Medicare Beneficiaries (QMB) outreach for Medicare members who qualify for both Part A and Part B. Ms. Khamseh informed the committee that during a routine regular audit it was determined that there were OneCare Connect members assigned to medical groups as opposed to a primary care physician. Those members were notified and CalOptima reassigned the members to the correct primary care physician. She also updated the committee on the annual Network Certification that is currently in process

Chief Medical Officer Update
David Ramirez, M.D., Chief Medical Officer, provided a brief update on the Pharmacy Carve-Out that has been renamed Medi-Cal Rx.

INFORMATION ITEMS

OCC MAC Member Updates
Chair Mouton notified the members that the Board at its August meeting approved the reappointments as recommended by this committee. Gio Corzo, Donald Stukes, Keiko Gamez and Patty Mouton were reappointed for a two year term ending June 30, 2022. She also reminded the members that they would receive information on the annual CalOptima compliances courses and that they would receive notification of these courses around September 8, 2020. She asked the member to please complete them by the deadline. She also reminded the members of the joint meeting with the other Board Advisory Committees on October 8, 2020 at 8 AM.

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

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

Annual HEDIS Update
Irma Munoz, Project Manager Lead, Quality Analytics, gave a brief presentation on CalOptima's annual HEDIS results. Ms. Munoz discussed DHCS regulatory reporting for Managed Care plans which is called the Managed Care Accountability Set (MCAS) and the National Committee for Quality Assurance (NCQA) accreditation scores. Ms. Munoz noted that the medical records data collection had

Back to Agenda

faced challenges due to COVID-19, and that CalOptima was successful in meeting all the DHCS Minimum Performance Levels.

ADJOURNMENT

Chair Mouton announced that the next regular meeting would be held on Thursday, August 27, 2020 at 3:00 p.m.

Hearing no further business, the meeting adjourned at 4:38 p.m.

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

Approved: October 22, 2020

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Authorizing and Directing Execution of a New Agreement with the California Department of Health Care Services for the CalOptima Program of All-Inclusive Care for the Elderly

Contacts

David Ramirez, M.D., Chief Medical Officer, (714) 347-3261
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute a new Agreement for the Program of All-Inclusive Care for the Elderly (PACE) between the California Department of Health Care Services (DHCS) and CalOptima with a contract termination date through December 31, 2024, with the DHCS capitation rates renewed on a calendar year basis and changes in the contract terms that align with the 2019 Final Rule and Medi-Cal Managed Care Plan contract template.

Background

Since October 2009, the CalOptima Board has taken numerous actions related to the CalOptima PACE program. On June 6, 2013, the Board authorized the execution of the PACE Agreement between DHCS and CalOptima (DHCS PACE Agreement) as well as the agreement with the Centers for Medicare & Medicaid Services (CMS) for the operation of the CalOptima PACE site. Beginning in September 2015 and thereafter, the Board has authorized execution of various amendments to the DHCS PACE Agreement for calendar year (CY) payment rates and other provisions, as summarized in the attached Appendix.

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, with the capitation rates renewed on a CY basis. The current DHCS PACE Agreement expires on December 31, 2020.

Discussion

On August 26, 2020, DHCS provided CalOptima with a final redline version of the new DHCS PACE Agreement that replaces the current contract and all its amendments in its entirety. By way of background, from June 2019 through August 2020, DHCS was in the process of reviewing all the feedback and comments it had received from stakeholders. On June 21, 2019, DHCS released the initial draft version of a new template for the DHCS PACE Agreement for an opportunity to comment on the proposed changes. CalOptima staff submitted feedback, as did the CalPACE Association and other PACE organizations operating in other parts of the State. DHCS referred to this process as the "Contract Overhaul", instead of adding on subsequent Amendments to the existing DHCS PACE Agreement.

In June 2020, an Amendment was authorized to extend the current DHCS PACE Agreement through December 31, 2020, and CalOptima staff committed to return to the Board once the final Agreement was available, after DHCS vetted proposed changes with stakeholders was complete.

Back to Agenda

The new DHCS PACE Agreement will be:

- Effective January 1, 2021;
- Extend the contract termination date through December 31, 2024, with the DHCS capitation rates renewed on a CY basis; and
- Increase the maximum amount payable to accommodate the new term of the contract.

Summary of Language Updates

The following table summarizes the redline changes for the new DHCS PACE Agreement, in Appendix 2 for this Agenda item. The updates are intended to:

- Align the PACE contracts to conform provisions to those contained in the Managed Care Plan (MCP) *Medi-Cal* contracts; and
- Align PACE contracts with the 2019 PACE Final Rule issued by CMS last year.

CalOptima staff notes that while the volume of redlines are substantial throughout the various Exhibits, the redlined provisions in large part are not necessarily new regulatory requirements. CalOptima PACE is already in compliance with several of the "new" provisions. Examples of new provisions that are already met through current practices include mandated sensitivity training, monitoring of excluded individuals, and continuous Provider Training. The impact of new provisions that staff will address prior to the contract effective date mainly impact financial reporting and revising policy language. Nonetheless, all new provisions are outlined in the DHCS PACE Agreement.

Category	Type of Update	Update
General Change	Clarification language	Incorporates references throughout contract to various All Plan Letter (APLs) that is guidance for Medi-Cal MCPs. Updates references throughout the contract to point to current Code of Federal Regulations (CFRs), Title 28 - Health & Safety Code California Code of Regulations (CCRs), Title 22 CCRs, and Welfare & Institutions Code (WIC).
Exhibit A – Scope of Work		
Att. 1 - Organization and Administration of the Plan	Clarification language & new provisions	For conflict of interest, defines 5% or more as the threshold for triggering an updated Key Personnel Disclosure form, in addition to an annual filing. New provision to provide current organizational chart. New individual provision to reinforce medical decisions, including those by Sub-contractors and rendering providers, are not unduly influenced by fiscal and administrative management. Further elaborates on the provision to ensure monitoring that excluded individuals are not employed or contracted. New provision on Sensitivity Training. New provision noting DHCS reserves the right to conduct audits of mature PACE Organizations outside of the joint CMS audit(s).

Back to Agenda

Category	Type of Update	Update
		New provision on Oversight and Enforcement Authority, including corrective action plans, withholding of payments, sanctions and termination of contract.
Att. 2 - Financial Information	Clarification language & new provisions	Modifies timing of Financial Audit Report submission to 180 days (instead of 120) after the close of PACE's fiscal year. Eliminates provision on "*Line of Business Data Reporting & Financial Statements*". Modifies timing of Annual Forecasts to 60 days prior to the beginning of a new Fiscal year (instead of 30 days following the FY). New provision to prepare and submit a stand-alone Medi-Cal line of business income statement for each financial reporting period required. This income statement shall be prepared in the Department of Managed Health Care (DMHC) required financial reporting format.
Att. 3 - Management Information System	Clarification language & new provisions	Clarifies Encounter Data shall be submitted on at least a monthly basis in a form and manner specified by DHCS, and allows submission on a more frequent basis if preferable. New provision specifying DHCS will measure the quality of the Encounter Data for completeness, timeliness, reasonability, and accuracy.
Att. 4 - Quality Improvement Systems	Clarification language & new provisions	Modifies timing of submission of Quality Improvement report, from the end of the PACE fiscal year to on an annual basis. New provision on ensuring all contracted laboratory testing sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. Eliminates requirement for PACE providers to also be Medi-Cal enrolled. New provision to maintain member dental records and implement a system to review dental records.
Att. 5 - Utilization Management (UM)	Clarification language & new provisions	New provision specifying additional details for UM Program. New provision specifying additional details for Timeframes for different types of Medical Authorizations (Emergency, Non-Urgent, Concurrent review, Retrospective review, Pharmaceuticals, Routine, Expedited and Hospice Inpatient Care).
Att. 6 - Provider Network	Clarification language & new provisions	New provision specifying PACE shall ensure and monitor an appropriate provider network, including PCPs, specialists, professional, allied, supportive paramedical personnel, and an adequate number of accessible inpatient facilities and PACE Centers within each service area. New Provision specifying a designated emergency service facility, providing care on a 24 hours a day, seven days-per-

Back to Agenda

Category	Type of Update	Update
		week basis. This designated emergency service facility will have one or more Physicians and one or more nurses on duty in the facility at all times. New provision for PACE to meet federal requirements for access to Federally Qualified Health Center (FQHC) services. For quarterly updated subcontractor listing, PACE shall notify DHCS in the event the agreement with the Subcontractor is amended or terminated. Further elaborates on Subcontract requirements.
Att.7 - Provider Relations	Clarification language & new provisions	Further elaborates on Provider Manual requirements, including specific Member Rights, Grievance and Appeals and State Hearing information. Modifies the timing of Provider's PACE Training requirement to take place prior to commencement of services to Participants (instead of within 10 working days after contracting). New provision for a process to provide Provider Training on a continuing basis regarding clinical protocols, evidenced-based practice guidelines and DHCS-developed cultural awareness and sensitivity instruction for SPDs or persons with chronic conditions.
Att. 8 - Provider Compensation Arrangements	Clarification language & new provisions	Modifies the compensation provision for subcontractors to allow it to be determined by a percentage of the payment from DHCS, unless DHCS objects, as well as by negotiation that the Provider and Contractor agree to. Modifies Claims Processing provisions to provide clarification. New provisions regarding reimbursements to FQHCs, Rural Health Clinics (RHC) and Indian Health Programs. Further elaborates on Post-Stabilization Services and requires PACE to establish and maintain a written plan which provides for coverage of urgently needed out-of-network and post-stabilization care services when certain criteria is met. Also clarifies the Medi-Cal payment amounts for post-stabilization services.
Att. 9 - Access and Availability	Clarification language & new provisions	New provisions to clarify and reinforce PACE-covered benefits of comprehensive medical, health, and social services that integrate acute and long-term care, and the requirement to have a written plan for each member (referred to as "plan of care" or "individual care plan"). New provision regarding ensuring telehealth is available and certain criteria is met. New provision for PACE to communicate, enforce, and monitor providers' compliance with these requirements.

Back to Agenda

Category	Type of Update	Update
		New provision for PACE to include procedures for follow-up on missed appointments. New provision specifying additional details for Emergency Care. Modifies timing of requirement to notify DHCS of changes in PACE Center location to 180 calendar days prior to effective date of changes (previously 30 days). Updates provisions for Nondiscrimination and Language Access. Updates provisions for Linguistic Services (oral & American Sign Language interpreters, TTY, translated materials). Eliminates provision on "*Healthcare Surge Events"*, which is now covered under the Emergency Preparedness Plan requirements. New provision to reinforce the use of out-of-network providers if PACE is unable to provide necessary covered services.
Att. 10 - Scope of Services	Clarification language & new provisions	New provision specifying that Medi-Cal benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost-sharing do not apply. Further elaborates on Immunization requirements. Modifies for clarification and additional specificity the Services for All Members: A. Health Education (makes health categories and topics more generalized) a. risk-reduction and healthy lifestyles; tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV; nutrition, weight control, and physical activity; and b. self-care and management of health conditions: asthma, diabetes; and hypertension. - PACE to cover and ensure provision of Comprehensive Case Management including coordination of care services B. Nursing Facility Services C. Vision Care: Lenses D. Mental Health Services E. Tuberculosis F. Pharmaceutical Services and Provision of Prescribed Drugs G. Transportation Services (New provision) H. Dietary Services (New provision)

Back to Agenda

Category	Type of Update	Update
Att.11 - Case Management and Coordination of Care	Clarification language & new provisions	New provision on Out-of-Plan Case Management and Coordination of Care New provision on Immunization Registry Reporting to be made following the Member's IHA and all other health care visits which result in an immunization being provided. New provision on the exclusion of Erectile Dysfunction (ED) Drugs and Other ED Therapies, unless such drug is used to treat a condition other than sexual or erectile dysfunction, and as approved by the Food and Drug Administration. ED drugs and other ED therapies are covered if they are determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.
Att. 12 - Local Health Department Coordination	Clarification language & new provisions	New Exhibit with provisions for Local Health Department Coordination for various types of services, referrals, and/or reporting: - STD services - HIV testing & counseling - Immunizations - Medi-Cal Mental Health Plan coordination
Att. 13 - Member Services	Clarification language & new provisions	Updates provisions for Member Rights & Responsibilities/ Participant Bill of Rights. New provision on Limiting use of Restraints. New provision on training program for PACE Staff and defines specific criteria for staff that has direct participant contact. New provisions specifying further details on requirements for written information: Definition, font size, reading-level, threshold languages, alternative format, disclaimers. Modifies the information that must be contained in the Member Enrollment/Terms and Conditions (increased from 26 to 30 elements).
Att. 14 - Member Grievance and Appeals	Clarification language & new provisions	New provision to include definition of a grievance and elaborate on the minimum requirements for process, notification, resolution and analyzing grievance information. New provision on handling Discrimination Grievances. Updates provisions on Member Notification of Denial, Deferral or Modification of Request for Prior Authorization, and Appeals.
Att. 15 - Marketing	Clarification language & new provisions	New provisions specifying additional details on Marketing and Prohibited Marketing Practices (aligning with CMS marketing guidance). Eliminate the provision that defines the elements of the Marketing Plan (PACE must still have a plan and submit to DHCS for approval, but no longer outlines the composition of the plan).

Back to Agenda

Category	Type of Update	Update
Att. 16 - Enrollments and Disenrollments	Clarification language & new provisions	New provision to delineate eligibility criteria and other eligibility requirements. Modifies for clarification and additional specificity the provisions on enrollment, disenrollment and information to Prospective participants. New provisions for distinguishing between Voluntary and Involuntary Disenrollment, and the process/timing requirements for each.
Att. 17 - Reporting Requirements	Clarification language & new provisions	New provision to report Inpatient Days information, within 30 calendar days of receipt of DHCS' written request.
Exhibit B - Budget Detail and Payment Revisions		
Budget Detail and Payment Provisions	Clarification language & new provisions	New provision on Amounts Payable. Updates provision on Capitation Rates for clarity on the amount specified and the schedule of payment. Updates the provision on Capitation Rates Constitute Payment in Full to modify the definition. New provision on Financial Performance Guarantee. New provision for Recovery of Capitation Payments related to retroactive disenrollment of Participants. Eliminates the provision related to improper or erroneous AIDS claim payments.
Att.1- Rate of Medi-Cal Reimbursements	Clarification language & new provisions	No changes. This Attachment is updated annually with new capitation payment rate information based on Medi-Cal Aid Code categories.
Exhibit E		
Att. 1 - Definitions	Clarification language & new provisions	Updates Definitions to incorporate new terms and modify some of the existing terms.
Att. 2 - Program Terms and Conditions	Clarification language & new provisions	Updates provision on Certifications requirements. Modifies the provision on Termination for Cause and Other Terminations to clarify and elaborate on criteria and timing. Modifies the provision on Notice to Members of Transfer of Care to specify a 60 day requirement prior to the proposed termination date to submit a detailed written plan for phase down to DHCS for approval prior to implementation. New provisions related to Phaseout Requirements for payment and activities. New provision to further elaborate on Sanctions provisions. New provision on Liquidated Damages to replace the former provision on Professional Review System.

Back to Agenda

Category	Type of Update	Update
		Updates the provisions on Notification of Dispute and Contracting Officer's or Alternate Dispute Officer's Decision for clarification. Modifies the Records Retention provision to increase the requirement to ten years (up from six). Updates the provision on Inspection Rights to incorporate references to the Department of Justice, Bureau of Medi-Cal Fraud, and Department of Managed Health Care. New provision that allows participation in Pilot Projects. New provisions on Fraud and Abuse Reporting, establishing an Anti-Fraud and Abuse Program and Tracking Suspended Providers. Updates the provision on Discrimination Prohibitions to specify the applicable categories it applies to. Updates the provision on Additional Federal Requirements, formerly specific to the Americans with Disabilities Act of 1990. New provision to incorporate the Federal False Claims Act Compliance. Eliminates provisions on Program Information, Compliance with Protocols and Reimbursement and Operations Reliance, that are further clarified and included elsewhere in the contract. Updates provision on Payment for Services, to incorporate actuarily sound capitation rates. Updates provision on Medical Review to further elaborate on DHCS' discretion authority, to eliminate duplication of auditing efforts.
Exhibit G		
HIPAA Business Associate Addendum	Replaced	Exhibit G, Attachment A, Health Insurance Portability and Accountability Act (HIPAA) of the contract has been replaced by Exhibit G, Business Associate Addendum.

Fiscal Impact

The recommended action to execute a new PACE Agreement between DHCS and CalOptima with a contract termination date through December 31, 2024, is a budgeted item, with no additional fiscal impact through June 30, 2021~~2020~~. The CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020, incorporated draft CY 2020 and forecasted CY 2021 PACE capitation rates. Management will include funding for the period of July 1, 2021~~2020~~, through December 31, 2024, in future operating budgets.

Rev. 11/5/20

Back to Agenda

Rationale for Recommendation

CalOptima's execution of the new DHCS PACE Agreement is necessary for the continued operation of CalOptima PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Appendix Summary of Amendments to PACE Primary Agreements
2. DHCS PACE Complete Overhaul Contract – Final Redline
3. Exhibit G HIPAA Addendum

/s/ Richard Sanchez *10/28/2020*
Authorized Signature **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM 5

The following is a summary of amendments to the PACE Primary Agreement approved by the CalOptima Board of Directors (Board) to date:

Amendments to Primary Agreement with DHCS	Board Approval
A01 provided revised Upper Payment Limit (UPL) and capitation rates for Calendar Year (CY) 2013 for the period of October 1, 2013 through December 31, 2013; and UPL methodology and CY 2014 rates for the period of January 1, 2014 through December 31, 2014. Revised capitation rates for the Medi-Cal *Dual* population and *Medi-Cal only* population to have built-in adjustments for Medi-Cal program changes. Also incorporated adult expansion group into aid code table: a. Added adult expansion aid codes M1, L1, 7U under adult expansion group. b. Added aid codes 3D and M3 under Family group.	September 3, 2015
A02 provided revised UPL and capitation rates for CY 2015 for the period of January 1, 2015 through December 31, 2015. Revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population to have built-in adjustments for Medi-Cal program changes.	September 3, 2015
A03 provided revised UPL and capitation rates for CY 2016 for the period of January 1, 2016 through December 31, 2016, and applied the Managed Care Organization (MCO) Tax for the period July 1, 2016 through December 31, 2016. Beginning on January 1, 2017 and onward, the rates revert back to the non-MCO tax period rates in effect from January 1, 2016 through June 30, 2016, until the 2017 rates are developed and implemented with a future amendment to the CalOptima DHCS PACE Agreement. Incorporates a revised HIPAA Business Associate Addendum, Exhibit H, to replace the former Exhibit G, as of the Amendment effective date, which will require compliance with DHCS' revised data security standards.	May 4, 2017
Amend* contract to include revised language reflecting the Americans with Disabilities Act (ADA) for 508 compliance. *On 9/20/17, DHCS informed CalOptima this would be moved to be captured in A04.	August 3, 2017
A04 provided an extension of the contract termination date to December 31, 2018 and incorporated ADA compliance language.	December 7, 2017
Future Amendment (A05) provided draft capitation rates for CY 2017 for the period of January 1, 2017 through December 31, 2017, developed by the "Amount That Would Have Otherwise Been Paid (AWOP)", and apply the Managed Care Organization (MCO) Tax for the period January 1, 2017 through June 30, 2017.	December 7, 2017

Back to Agenda Back to Item

Amendments to Primary Agreement with DHCS	Board Approval
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. Incorporates additional language updates for various contract provisions, including restrictions on delegation as well as emergency preparedness.	April 4, 2019
A08 provided revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2019 for the period of January 1, 2019 through December 31, 2019 and applies the Managed Care Organization (MCO) Tax for this period. Incorporates additional language updates for other contract provisions, including Nursing Facility Services payment rates.	September 5, 2019
A09 provided an extension of the contract termination date to June 30, 2020.	December 5, 2019
A10 provided an extension of the contract termination date to December 31, 2020 and also provides revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2020 for the period of January 1, 2020 through December 31, 2020.	June 4, 2020
New Primary Agreement: Replaces the previous contract and subsequent amendments in their entirety, effective January 1, 2021. Also extends the contract termination date to December 31, 2024, with DHCS capitation rates renewed on a calendar year basis. The new agreement aligns the PACE DHCS agreement with: • provisions contained in the Managed Care Plan (MCP) Medi-Cal contracts; and • provisions in the CMS 2019 Final Rule.	**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

Exhibit A, Attachment 1
Organization and Administration of the Plan

1. Legal Capacity

Contractor shall maintain the legal capacity to contract with DHCS and maintain all appropriate licenses, as determined by and at the sole discretion of DHCS, to operate a Program of All-Inclusive Care for the Elderly (PACE).

If Contractor does not operate a primary care clinic licensed to operate by the California Department of Public Health pursuant to California ~~Health and Safety~~ Code**,** section 1204, et seq., then Contractor must operate its primary care clinic in accordance with all requirements applicable to the operation of licensed ~~p~~**P**rimary ~~c~~**C**are clinics, subject to oversight and approval of the ~~Department of Health Care Services~~ **DHCS**. If Contractor fails to comply with the requirements for operation of a licensed primary care clinic, the ~~Department of Health Care Services~~ **DHCS** may require Contractor to submit a Corrective Action Plan **(CAP)**. If Contractor does not carry out the ~~Corrective Action Plan~~ **CAP** to comply with the requirements for operation of a licensed primary care clinic, the ~~Department of Health Care Services~~ **DHCS** may terminate this contract.

2. Key Personnel**:** Disclosure ~~Statement~~ **Form**

A. Contractor shall file an annual statement with ~~the~~ DHCS disclosing any purchases or leases of services, equipment, supplies or real property from an entity in which any of the following persons have a substantial financial interest:

1) ~~A~~**a**ny person ~~also~~ **or corporation** having **5% or more ownership or controlling** a substantial financial interest in Contractor**;**

2) ~~A~~**a**ny director, officer, partner, trustee**,** or employee of Contractor**; or**

3) ~~A~~**a**ny immediate family member of any person designated in (1) or (2) above.

Contractor shall ensure that individuals on ~~the organization's~~ **its** governing body, and their family members comply with conflict of interest requirement**s** specified in ~~42 Code of Federal Regulations (CFR)~~ **42 CFR,** Section 460.68(b) **and Welfare & Institutions Code Sections 14030, 14031, and 14032.**

B. Organizational Chart

Exhibit A, Attachment 1
Organization and Administration of the Plan

1) Contractor shall provide DHCS with a current organizational chart showing officials in the PACE organization and relationships to any other organizational entities. The organizational chart shall show where the Contractor PACE Organization relates to the other entities and the reporting structure from the governing body to the Contractor PACE organization.

2) The chart for a corporate entity must indicate the Contractor's relationship to the corporate board and to any parent, affiliate, or subsidiary corporate entities.

3) If Contractor is planning a change in organizational structure, it must notify DHCS, in writing, at least 14 days before the change takes effect.

3. Conflict of Interest: Current ~~A~~and Former State Employees

Contractor shall not utilize in the performance of this Contract any State officer or employee in the State civil service or other appointed State official **whose employment with the State in any way involves or is related to the operation, oversight, approval, contracting or establishment of PACE plans,** unless the employment, activity or enterprise is required as a condition of the officer's or employee's regular state employment. **For purposes of this subsection only, ~~E~~e**mployee in the State civil service ~~is defined to be~~ **means** any person legally holding a permanent or intermittent position in the State civil service.

4. Contract Performance

Contractor shall maintain the organization and staffing for implementing and operating the Contract **in accordance with Title 28, CCR, Section 1300.67.3 (28 CCR 1300.67.3) and Title 22 CCR Sections 53800, 53851 and 53857**. Contractor shall ensure the following:

A. ~~The organization~~ **Contractor** has an accountable governing body with full legal authority and responsibility, as required in 42 CFR, Section 460.62(a).

B. This Contract is a high priority and ~~that the~~ Contractor is committed to supplying necessary resources to assure full performance of the Contract.

Exhibit A, Attachment 1
Organization and Administration of the Plan

C. If ~~the~~ Contractor is a subsidiary ~~organization~~, the attestation of the parent organization that this Contract shall be a high priority to the parent ~~organization~~, and that the parent ~~organization~~ is committed to supplying any **and all** necessary resources to assure full performance of the Contract.

D. ~~A~~ **Contractor has a** full-time Program Director ~~to administer the day-to-day business activities of Contractor~~ **who is responsible for the oversight and administration of the PACE plan, as required by 42 CFR 460.60**.

E. **Contractor has** ~~S~~**s**ufficient support staff to conduct Contractor's daily business in an orderly manner, as determined through management, medical, dental, and fiscal reviews **conducted or requested by DHCS**.

F. ~~Participant~~ **Contractor's** representation on the ~~G~~**g**overning body ~~is required on~~ **includes a member representative when** issues related to ~~Participant~~ **member** care, ~~pursuant to~~ **are under consideration, as required by** 42 CFR, Section 460.62(c).

G. **Contractor has** ~~Establishment of~~ **established** a ~~p~~**P**articipant advisory committee, ~~pursuant to~~ **as required by** 42 CFR~~, Section~~ 460.62(b).

H. If Contractor is planning ~~a change in the~~ **to change its** organizational structure, written notification **describing that change** must be provided to ~~the~~ DHCS, at least 14 days before the change would take effect, ~~for approval~~ **in order to obtain DHCS approval to continue this contract under the new organizational structure in compliance with Medi-Cal and Medicaid laws and regulations**.

I. Contractor shall:

1) collect data;

2) maintain, and afford DHCS access to, the records relating to the program, including pertinent financial, medical, and personnel records;

3) make available to DHCS reports that DHCS considers necessary to monitor the operation, cost, and effectiveness of the PACE program;

4) during the first 3 years of operation of a PACE program, provide such additional data as DHCS specifies in order to

perform the oversight required during the initial 3 year trial period;

5) maintain records and report data in compliance with 42 U.S.C. Section 1395eee(e)(3) and 42 CFR 460.32(a)(11), 460.202, 460.204, 460.208, and 460.210.

J. Contractor shall meet all applicable requirements under Federal, State, and local laws and regulations, including Section 1557 of the Affordable Care Act, the Civil Rights Act, the Age Discrimination Act, Section 504 of the Rehabilitation Act, the Americans With Disabilities Act, and Section 11135 of the Government Code.

5. Medical Decisions

Contractor shall ensure that medical decisions, including those by Sub-contractors and rendering providers, are not unduly influenced by fiscal and administrative management.

5~~6~~6. Program Director

Contractor shall maintain a full-time Program Director who**se duties include,** ~~shall assume~~, but **may** not be limited to, the following responsibilities:

A. Ensur**ing** oversight and administration within the organization~~.~~**;**

B. Ensur**ing** that **decisions concerning** medical, social, and supportive services decisions are not unduly influenced by fiscal or administrative management~~.~~**;**

C. Ensur**ing** that appropriate personnel perform their functions within the organization~~.~~**; and**

D. Inform**ing** employees and contracted providers of applicable organization policies and procedures.

~~6~~7. Medical Director

Contractor shall maintain a **full time** ~~P~~**p**hysician as Medical Director**, in compliance with 42 CFR section 460.60,** ~~who shall assume the following responsibilities~~ **whose responsibilities shall include, but not be limited to, the following**:

Exhibit A, Attachment 1
Organization and Administration of the Plan

A. Ensuring that medical decisions are:

1) rendered by qualified medical personnel; and

2) are not unduly influenced by fiscal or administrative management considerations;

~~A~~**B**. ~~E~~**e**nsur**ing** that **provided** medical care ~~provided~~ meets **or exceeds** the standards for acceptable medical care~~.~~**;**

~~B~~**C**. ~~E~~**e**nsur**ing** that medical protocols and rules of conduct for plan medical personnel are followed~~.~~**;**

~~C~~**D**. ~~D~~**d**develop**ing** and implement**ing** medical policy~~.~~**;**

~~D~~**E**. ~~R~~**r**esolv**ing** ~~medically related G~~**g**rievances **related to quality of medical care**~~.~~**;**

~~E~~**F**. ~~Have a significant role in Contractor's Quality Improvement System (QIS)~~ **actively participating in Contractor's grievance procedures; and**

~~F~~**G**. ~~Have a significant role in Contractor's Quality Improvement System (QIS)~~ **actively participating in the implementation of Quality Improvement (QI) activities**.

~~G. Achieve the best clinical outcomes possible for all Members.~~

~~H. Ensure medical decisions are rendered by qualified medical personnel and are not influenced by fiscal or administrative management considerations.~~

~~7~~8. Medical Director Changes

Contractor shall report to DHCS any changes in the status of the Medical Director within ~~10~~ **ten calendar** days.

~~8~~9. Administrative Duties/Responsibilities

Contractor shall maintain the organizational and administrative capabilities to carry out its duties and responsibilities under the Contract. This shall include, at a minimum, the following:

Exhibit A, Attachment 1
Organization and Administration of the Plan

A. ~~E~~**e**nsur**ing** personnel meet all **applicable** ~~S~~**s**tate licensure, certification, or registration requirements~~.~~**;**

B. ~~Ensure~~ **providing** on-going training, ~~pursuant to~~ **as required by** 42 CFR, Section 460.66(a)~~.~~**;**

C. ~~E~~**e**nsur**ing** patient safety and to achieve patient-specific performance measures requiring actions necessary of each staff member (employee**s** and contractors) to address different medical and non-medical emergencies~~.~~**;**

D. Ensuring Contractor does not employ or contract with organizations or individuals:

1) who have been excluded from participation in the Medicare or Medicaid programs;

2) who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, other health insurance or health care programs, or social service programs under title XX of the Social Security Act;

3) If the PACE organization determines that an individual's contact with participants would pose a potential risk because the individual has been convicted of one or more criminal offenses related to physical, sexual, drug, or alcohol abuse, or use;

4) who have been found guilty of abusing, neglecting, or mistreating individuals by a court of law or who have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents, or misappropriation of their property; or

5) who have been convicted of specific crimes for any offense described in section 1128(a) of the Social Security Act.

Contractor shall have a formal process in place to gather information related to this paragraph and shall respond in writing to a request for information from DHCS within a reasonable amount of time.

Exhibit A, Attachment 1
Organization and Administration of the Plan

Contractor shall comply with the requirements of 42 CFR 460.86 regarding payment to individuals and entities excluded by the Office of the Inspector General or included on the preclusion list.

~~D. Contractor does not employ any staff (employees or contractors) who have been convicted of criminal offenses, pursuant to 42 CFR, Section 460.68(a).~~

E. Designat**ing** persons qualified by training or experience, to be responsible for the Medical Record service~~.~~**;**

F. **establishing and maintaining M**~~m~~ember **E**~~e~~nrollment and Disenrollment reporting systems**.**

G. **establishing and maintaining m**ember **g**rievance and **a**ppeals procedures**, as specified in Exhibit A, Attachment 14.**

H. **establishing and maintaining d**ata reporting capabilities sufficient to provide necessary and timely reports to DHCS**, as required in Exhibit A, Attachment 3, and elsewhere in this contract.**

I. **maintaining f**inancial records and books of account maintained on the accrual basis, in accordance with Generally Accepted Accounting Principles (GAAP), which fully disclose**s** the disposition of all Medi-Cal program funds received**, as specified in Exhibit A, Attachment 2.**

J. **establishing and maintaining c**laims processing capabilities **as described in Exhibit A, Attachment 8.**

K. Maintaining and affording DHCS access to the records relating to the program, including pertinent financial, medical, and personnel records.

L. Making available to DHCS reports that DHCS finds necessary to monitor the operation, cost, and effectiveness of the PACE program.

M. Cooperating with DHCS in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

N. Identifying members of Contractor's governing body or any immediate family member having a direct or indirect interest in any contract that supplies any administrative or care-related service or materials to the PACE organization.

Exhibit A, Attachment 1
Organization and Administration of the Plan

1) Contractor shall develop policies and procedures for handling any direct or indirect conflict of interest by a member of the governing body or by the member's immediate family.

2) In the event of a direct or indirect conflict of interest by a member of Contractor's governing body or his or her immediate family member, the board member must—

   a. Fully disclose the exact nature of the conflict to the board of directors and have the disclosure documented; and

   b. Recuse himself or herself from discussing, negotiating, or voting on any issue or contract that could result in an inappropriate conflict.

3) Contractor shall have a formal process in place to gather information related to this paragraph and must be able to respond in writing to a request for information from CMS and/or DHCS within a reasonable amount of time.

10. Member Representation

Contractor shall ensure that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD) and persons with chronic conditions (such as asthma, diabetes, and congestive heart failure), are represented and participate in establishing public policy within the Contractor's Participant Advisory Committee.

11. Sensitivity Training

Contractor shall ensure that all personnel who interact with beneficiaries, as well as those who may potentially interact with beneficiaries, and any other staff deemed appropriate by Contractor or DHCS, shall receive sensitivity training.

12. Contract Oversight During Trial Period

Contractor shall be subject to annual, close oversight during the trial period, meaning the first 3 contract years as a PACE provider, as set forth in 42 U.S.C. Section 1496eee(e)(4) and 42 CFR 460.190. During the trial period, CMS and DHCS conduct a comprehensive annual review of the operation of Contractor's PACE program in order to assure compliance with the legal and contractual requirements. Such a review shall include--

Exhibit A, Attachment 1
Organization and Administration of the Plan

A. an on-site visit to the program site;

B. comprehensive assessment of Contractor's fiscal soundness;

C. comprehensive assessment of Contractor's capacity to provide all PACE services to all enrolled members;

D. detailed analysis of Contractor's substantial compliance with all significant requirements of federal and state law and regulations; and

E. any other elements the Secretary or DHCS considers necessary or appropriate.

After the trial period, CMS in cooperation with DHCS will continue to conduct such review of the operation of Contractor and its PACE program as may be appropriate, taking into account Contractor's performance level and compliance with all significant requirements of law and regulations pursuant to 42 CFR 460.192

DHCS reserves the right to conduct audits of mature PACE Organizations outside of the joint CMS audit(s) as described above. This requirement is to ensure that all PACE Organizations comply with current state requirements along with contractual deliverables. The audits shall include but not limited to: an on-site visit at least every 3 years or as appropriate to address program deliverables, monitoring and oversight activities ensuring program compliance. The results of these reviews will be reported promptly to Contractor, along with any recommendations for changes to the Contractor's program, audit findings may be posted online to provide transparency.

As described in 42 CFR 460.194, Contractor must take action to correct deficiencies identified during reviews. CMS and/or DHCS monitors the effectiveness of the corrective actions. Failure to correct deficiencies may result in sanctions or termination. Disclosure of the review results is governed by 42 CFR 460.196.

13. Oversight and Enforcement Authority

A. In general

If it is determined by DHCS or the Centers for Medicare and Medicaid Services (CMS) that Contractor is failing substantially to comply with the requirements of federal or state laws or regulations, CMS and DHCS may take any or all of the following actions:

Exhibit A, Attachment 1
Organization and Administration of the Plan

1) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

2) Withhold some or all further payments under the PACE program agreement under 42 USC Section 1395eee(e)(6) or Section 1396u-4 with respect to PACE program services furnished by Contractor until the deficiencies have been corrected.

3) Terminate such agreement.

B. Application of intermediate sanctions

CMS may provide for the application against Contractor of remedies described in section 42 USC Sections 1395w-27(g)(2) or 1396b(m)(5)(B in the case of violations by the Contractor of the type described in sections 1395w-27(g)(1) or 1396b(m)(5)(A) of this title, respectively (in relation to agreements, enrollees, and requirements under this section or section 1396u-4, respectively).

C. DHCS Actions

DHCS may take enforcement action with respect to Contractor as described in Welfare & Institutions Code Section 14304.

Exhibit A, Attachment 2
Financial Information

1. Financial Viability/Standards Compliance

Contractor shall **comply with the requirements of 42 CFR 460.80, and** meet and maintain financial viability/standards compliance to DHCS' satisfaction for each of the following elements**.** ~~:~~ **To the extent that there is any conflict between State and federal law, or between this contract and federal law, the stricter of the requirements shall apply.**

A. Tangible Net Equity (TNE)

Contractor **at all times** shall ~~maintain a~~ **be in compliance with the** TNE ~~equal to one month's Capitation~~ **requirements 28, CCR, Section 1300.76**.

B. Administrative Costs

Contractor's ~~A~~**a**dministrative ~~C~~**c**osts shall not exceed the standards ~~as~~ established under Title 2~~2~~**8**, CCR, Section ~~53864(b)~~ **1300.78**.

C. Standards of Organization and Financial Soundness

Contractor shall provide, and update as changes occur, a description of its organizational structure and information on administrative contacts including the following;

1) name and phone number of the program director;

2) name of all governing body members; and

3) name and phone number of a contact person for the governing body.

~~1)~~ Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with Title 28, CCR, Sections 1300.67.3, 1300.75.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and ~~Cal. Code Regs., tit.~~Title 22 **CCR** ~~s~~**S**ections 53851, ~~53863,~~ and 53864.

~~2) If the organization conducting the day-to-day operations of the program is a subsidiary entity within a larger parent company, a separation of duties must be clearly established between the two entities in Contractor's operating policies and procedures and in its financial record keeping. A separate financial statement must be~~

~~maintained for this entity, which includes but is not limited to the balance and income statements. The financial reserve requirements specified in Exhibit B, Budget Detail and Payment Provisions, provision 10. Financial Performance Guarantee must be held in a separate bank account clearly designated as the specific program reserve account. The funds in this account shall not be commingled with the reserves for any other program.~~

~~D. Working capital and current ratio of one of the following:~~

~~1) Contractor shall maintain a working capital ratio of at least 1:1; or~~

~~2) Contractor shall demonstrate to DHCS that Contractor is now meeting financial obligations on a timely basis and has been doing so for at least the preceding two years; or~~

~~3) Contractor shall provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current.~~

2. Financial Audit ~~/~~ Reports

Contractor shall ensure that an annual audit is performed ~~according to the Welfare and Institutions (W&I) Code, Section 14459~~. **A financial statement, audited by a** Certified Public Accountant~~'s~~ (CPA) ~~audited Financial Statements~~ shall be submitted to DHCS no later than ~~120~~ **180** calendar days after the close of the Contractor's fiscal year. Combined ~~F~~**f**inancial ~~S~~**s**tatements shall be prepared to show the financial position of the overall related health care delivery system when delivery of care or other services ~~is~~ **are** dependent upon Affiliates. Financial ~~S~~**s**tatements shall be presented in a form that clearly shows the financial position of Contractor separately from the combined totals. Inter-entity transactions and profits shall be eliminated if combined statements are prepared. Contractor shall have separate certified ~~F~~**f**inancial ~~S~~**s**tatements prepared if an independent accountant decides that preparation of combined statements is inappropriate.

A. The independent accountant shall state in writing reasons for not preparing combined ~~F~~**f**inancial ~~S~~**s**tatements.

B. Contractor shall provide supplemental schedules that clearly reflect all inter-entity transactions and eliminations necessary to enable DHCS to

analyze the overall financial status of the entire health care delivery system.

1) In addition to annual certified ~~F~~**f**inancial ~~S~~**s**tatements Contractor shall complete the State Department of Managed Health Care (DMHC) required financial reporting forms. The CPA audited ~~F~~**f**inancial ~~S~~**s**tatements and **the** DMHC required financial reporting forms shall be submitted to DHCS no later than ~~120~~ **180** calendar days after the close of Contractor's Fiscal Year **(FY)**.

2) If Contractor is a public entity or a political subdivision of the ~~S~~**s**tate and a county grand jury conducts Contractor's financial audits, Contractor shall submit its financial statement within 180 calendar days after the close of ~~Contractor's Fiscal Year~~ **the FY** in accordance with Health and Safety Code, section 1384.

3) Contractor shall submit to DHCS within 45 calendar days after the close of Contractor's fiscal quarter, quarterly financial reports required by Title 22~~,~~ CCR~~,~~ Section 53862(b)(1). The required quarterly financial reports shall be prepared on DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

   a. Jurat**;**

   b. Report 1A and 1B: Balance Sheet**;**

   c. Report 2: Statement of Revenue, Expenses, and Net Worth**;**

   d. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for GAAP compliance)**;**

   e. Report 4: Enrollment and Utilization Table**;**

   f. Schedule F: Unpaid Claims Analysis**;**

   g. Appropriate footnote disclosures in accordance with GAAP**; and**

   h. Schedule H: Aging Of All Claims.

Exhibit A, Attachment 2
Financial Information

C. Contractor shall authorize the independent accountant to allow ~~representatives of~~ DHCS **designated representatives or agents**, upon written request, to inspect any and all working papers related to the preparation of the audit report.

D. Contractor shall submit to DHCS all financial reports relevant to Affiliates as specified in Title 22~~,~~ CCR~~,~~ Section 53330(a)(1) **and 53862(c)(4)**.

E. Contractor shall submit to DHCS copies of any financial reports submitted to other public or private organizations as specified in Title 22, CCR, Section 53324(d).

3. Monthly Financial Statements

If Contractor and/or subcontractor is required to file monthly ~~F~~**f**inancial ~~S~~**s**tatements with the ~~California Department of Managed Health Care (~~DMHC~~)~~, Contractor and/or subcontractor shall file an exact copy of the monthly ~~F~~**f**inancial ~~S~~**s**tatements with DHCS. Contractor and/or subcontractor shall submit monthly financial statements to DHCS upon request, if deemed necessary, to monitor the Contractor and/or subcontractor's financial viability.

Contractor shall submit to DHCS no later than 30 calendar days after the close of Contractor's fiscal month, monthly financial reports in accordance with Title 22~~,~~ CCR~~,~~ Section 53862(c)(6). Monthly financial reports shall be prepared on the DMHC- required financial reporting forms and shall include, at a minimum, the following reports/schedules:

A. Jurat**;**

B. Report 1A and 1B: Balance Sheet**;**

C. Report 2: Statement of Revenue, Expenses, and Net Worth**;**

D. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for ~~Generally Accepted Accounting Principles (~~GAAP~~)~~ compliance~~.~~)**;**

E. Report 4: Enrollment and Utilization Table**;**

F. Schedule F: Unpaid Claims Analysis**;**

Exhibit A, Attachment 2
Financial Information

G. ~~A~~**a**ppropriate footnote disclosures in accordance with GAAP**; and**

H. Schedule H: Aging of All Claims.

4. Annual Financial Statements

Contractor shall submit to DHCS no later than ~~120~~ **180** calendar days after the close of Contractor's fiscal year, annual financial reports. Contractor's annual financial reports shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

A. Jurat**;**

B. Report 1A and 1B: Balance Sheet**;**

C. Report 2: Statement of Revenue, Expenses, and Net Worth**;**

D. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for ~~Generally Accepted Accounting Principles (~~GAAP~~)~~ compliance~~.~~)**;**

E. Report 4: Enrollment and Utilization Table**;**

F. Schedule F: Unpaid Claims Analysis**;**

G. ~~A~~**a**ppropriate footnote disclosures in accordance with GAAP**; and**

H. Schedule H: Aging of All Claims.

~~**5. Line of Business Data Reporting and Financial Statements**~~

~~Contractor shall prepare and submit the PACE Utilization Report and PACE Line of Business Report on a semi-annual basis. These reports shall include, at a minimum, the following:~~

~~A. PACE Utilization Report: Cumulative statement of utilization by each service category and funding source over a 6 month period.~~

~~B. PACE Line of Business Report: This report shall be used to translate enrollee utilization to financial reporting along all revenue/expense streams. The Contractor shall use this report to track the total revenue for~~

~~each funding source as well as the expenses paid out for each PACE service category and general administrative costs.~~

~~C. Contractor shall submit these reports no later than 45 calendar days following the end of the six month period.~~

~~6~~5. Annual Forecasts

~~Contractor shall submit to DHCS no later than 30 calendar days following the beginning of Contractor's fiscal year, an annual forecast for Contractor's next fiscal year. Contractor's annual forecast shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:~~

Contractor shall submit to DHCS at least 60 days prior to the beginning of the FY, an annual forecast for the next FY.

Contractor's annual forecast shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

A. Report 2: Statement of Revenue, Expenses, and Net Worth by County. (Medi-Cal line of business)**;**

B. Report 4: Enrollment and Utilization Table by County. (Medi-Cal line of business)**;**

C. TNE (All lines of business)**; and**

D. ~~A~~**a** detailed explanation of all underlying assumptions used to develop the forecast.

~~7~~6. Compliance with Audit Requirements

Contractor shall cooperate with ~~DHCS'~~ audits **by DHCS, CMS, and any of their related entities or agents**. Such audits may be waived**, but is not required to be waived, by the auditing entity** upon submission of the financial audit for the same period conducted by DMHC pursuant to Health and Safety Code section 1382.

Exhibit A, Attachment 2
Financial Information

~~8~~7. Submittal of Financial Information

A. Contractor shall prepare financial information~~, including financial statements and projections/forecasts~~ requested in accordance with GAAP. **Where financial statements and projections/forecasts are requested,** ~~T~~**t**hese statements and projections/forecasts should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions ~~F~~**f**ormat. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found under Title 28, CCR, Section 1300.51 et. seq. Information submitted shall be based on current operations. Contractor and/or subcontractors shall submit financial information consistent with filing requirements of t~~he~~ DMHC unless otherwise specified by DHCS.

B. Contractor shall prepare and submit a stand-alone Medi-Cal line of business income statement for each financial reporting period required. This income statement shall be prepared in DMHC required financial reporting format.

~~9~~8. Fiscal Viability of Subcontracting Entities

Contractor shall maintain a system to evaluate and monitor the financial viability of all risk bearing subcontracting provider groups including, but not limited to, HMOs, independent ~~physician~~**Physician**/provider associations (IPAs), medical groups, and Federally Qualified Health Centers **(FQHCs)**.

~~10~~9. Contractor's Obligations

Contractor is required under the terms of this Contract to provide any other financial reports/information not listed above as deemed necessary by DHCS to properly monitor the Contractor and/or subcontractor's financial condition. ~~The Contractor shall provide all requested material to DHCS within 45 calendar days.~~

Exhibit A, Attachment 3
Management Information System

1. Management Information System (MIS) Capability

A. Contractor's MIS shall have the capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data quality and timeliness requirements of DHCS's ~~e~~**E**ncounter ~~d~~**D**ata submission. All data related to this **C**~~c~~ontract shall be available to DHCS and to the Centers to Medicare and Medicaid Services **(CMS)** upon request. Contractor shall have and maintain a MIS that provides, at a minimum:

1. All Medi-Cal eligibility data**;**
2. Information of Members enrolled in Contractor's plan**;**
3. Provider claims status and payment data**;**
4. Health care services delivery **E**~~e~~ncounter **D**~~d~~ata**;**
5. Provider network information**;** and
6. Financial information as specified in Exhibit A, Attachment 1, Provision 8~~, Administrative Duties/Responsibilities~~.

B. Contractor's MIS shall have processes that support the interactions between Financial, Member/Eligibility, Provider, Encounter Claims, Quality Management/Quality Improvement/Utilization; and Report Generation subsystems. The interactions of the subsystems must be compatible, efficient**,** and successful.

2. Encounter Data Submittal

A. Contractor shall implement policies and procedures for ensuring the complete, accurate, and timely submission of ~~e~~**E**ncounter ~~d~~**D**ata **to DHCS, as defined in state and federal law and applicable DHCS APLs,** for all **items and** services for which Contractor has incurred any financial liability **furnished to a Member under this contract**, whether directly or through subcontracts or other arrangements**, including capitated providers**. Encounter ~~d~~**D**ata shall **be submitted on at least a monthly basis in a form and manner specified by DHCS** ~~include data elements specified in DHCS' most recent Encounter Data Element Dictionary for Managed Care Plans and all existing MMCD Policy Letters related to encounter data reporting~~.

Exhibit A, Attachment 3
Management Information System

B. Contractor shall require subcontractors and non-contracting providers to provide ~~e~~**E**ncounter ~~d~~**D**ata to Contractor, which allows the Contractor to meet its administrative functions and the requirements set forth in this section. Contractor shall also have in place mechanisms, including edits and reporting systems sufficient to ~~assure~~ **ensure** ~~e~~**E**ncounter ~~d~~**D**ata is complete and accurate prior to submission to DHCS.

C. Contractor shall submit **complete, timely, reasonable, and accurate** **E**~~e~~ncounter **D**~~d~~ata **on at least a monthly basis. DHCS will also allow Contractor to submit on a more frequent basis if preferable.** ~~to DHCS upon the request of DHCS. The implementation of regular encounter data reporting timeframes will be aligned with the DHCS implementation of a standardized encounter data reporting format. DHCS maintains its right to change the frequency, and if DHCS were to revise the timeframe then DHCS shall provide at least 30 calendar day notice of the change to the Contractor. DHCS may hold the Contractor accountable to requirements specified in the most recent Encounter Data Element Dictionary for Managed Care Plans and all existing Policy Letters related to encounter data reporting.~~

D. DHCS will measure the quality of the Encounter Data for completeness, timeliness, reasonability, and accuracy.

~~D~~**E**. **If DHCS finds deficiencies regarding Encounter Data or the quality of Encounter Data, DHCS may notify Contractor in writing of the deficiency and request correction and resubmission of the relevant Encounter Data.** ~~Upon written notice by DHCS that the encounter data is insufficient or inaccurate,~~ Contractor shall ensure that corrected data is resubmitted within 15 calendar days of ~~receipt~~ **the date** of DHCS' notice. Upon Contractor's written request, DHCS may provide a written extension for submission of corrected ~~e~~**E**ncounter ~~d~~**D**ata.

3. MIS/Data Correspondence

Upon receipt of written notice by DHCS of any problems related to the submittal of data to DHCS, or any changes or clarifications related to Contractor's MIS system, Contractor shall submit to DHCS a ~~Corrective Action Plan~~ **CAP** with measurable benchmarks within 30 calendar days from the date of the postmark of DHCS' written notice to Contractor. Within 30 calendar days of DHCS' receipt of **CAP**, DHCS shall approve the ~~Corrective Action Plan~~ **CAP** or request revisions. Within 15 calendar days after receipt of a request for revisions to the ~~Corrective Action Plan~~ **CAP,** Contractor shall submit a revised ~~corrective Action Plan~~ **CAP** for DHCS**'** approval. **DHCS may continue to request revisions to**

Exhibit A, Attachment 3
Management Information System

the CAP until it is finally approved by DHCS, or until DHCS determines that Contractor is not acting in good faith to comply with the contract requirement to submit data. If contractor is not complying with the timelines identified in its approved CAP, contractor is not acting in good faith. If DHCS determines that Contractor is not acting in good faith to comply with the requirement to submit data, then DHCS may issue sanctions and/or terminate the contract as provided in Welfare & Institutions Code Section 14304.

4. Health Insurance Portability and Accountability Act (HIPAA)

Contractor shall comply with Exhibit G, Health Insurance Portability and Accountability Act (HIPAA) requirements, and all related **f**~~F~~ederal and **s**~~S~~tate regulations ~~promulgated from this Act~~, as they become effective.

Back to Agenda Back to Item

Exhibit A, Attachment 4
Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) **in accordance with 42 CFR 460.32(a)(9), 460.130, 460.132, 460.134, 460.136, 460.138, and 460.140, and the standards in 28 CCR Section 1300.70.** Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services, on its behalf, in any setting. Contractor shall be accountable for the quality of all **c**overed **s**ervices regardless of the number of Contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

2. Accountability

Contractor shall maintain a system of accountability which includes the participation of the governing body of Contractor's organization, the designation of a Quality Improvement Committee **(QIC)** with oversight and performance responsibility, the supervision of activities by the Medical Director, and the inclusion of employed or contracted Physicians and contracting providers in the process of QIS development and performance review. Participation of non-contracting providers is discretionary.

3. Governing Body

Contractor shall implement and maintain policies that specify the responsibilities of the governing body**, in compliance with 42 CFR 460.62, and** including, at a minimum, the following:

A. A**a**pproves the overall QIS and the annual report of the QIS**;**.

B. A**a**ppoints an accountable entity or entities within Contractor's organization to provide oversight of the QIS**;**.

C. R**r**outinely receives written progress reports from the QIS committee describing actions taken, progress in meeting QIS objectives, and improvements made**; and**.

D. Formally reviews (at least annually) a written report on the QIS which includes; studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered; and assess the QIS' continuity, effectiveness, and current acceptability.

Exhibit A, Attachment 4
Quality Improvement System

~~E~~**D**. Directs the operational QIS to be modified on an ongoing basis and tracks all review findings for follow-up.

4. Quality Improvement Committee

A. Contractor shall implement and maintain a ~~Quality Improvement Committee (~~QIC~~)~~ designated by and accountable to the governing body**.**~~;~~ **The QIC** ~~the committee~~ shall be facilitated by the Medical Director or a Physician designee. Contractor must ensure that ~~s~~**S**ubcontractors, who are representative of the composition of the contracted provider network, including but not limited to ~~s~~**S**ubcontractors who provide health care services to ~~Seniors and Persons with Disabilities~~ **SPDs and persons with** ~~or~~ chronic conditions (such as asthma, diabetes, **and** congestive heart failure), actively participate on the committee or medical sub-committee that reports to the QIC. ~~The role, structure, and function of this committee shall be delineated.~~

B. The committee shall meet at least quarterly, but as frequently as necessary, to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body, in writing, on a scheduled basis.

C. Contractor shall ensure that a summary of quality assurance activities are submitted to DHCS quarterly ~~for review~~. Contractor shall maintain a process to ensure rules of confidentiality are maintained in quality improvement discussions as well as avoidance of conflict of interest on the part of the Members.

D. Contractor shall ensure that the Medical Director shall be directly involved in the implementation of Quality Improvement activities.

5. Provider Participation

A. Contractor shall ensure that **contracting** ~~P~~**p**hysicians and other ~~health care~~ providers **from the community** shall be involved as an integral part of the QIS. Contractor shall maintain and implement appropriate procedures to keep **contracting** providers informed of the written QIS, its activities and outcomes.

B. Contractor shall maintain employment agreements and provider Contracts, which include a requirement securing cooperation with the QIS. Contractor shall ensure that contracted hospitals and other subcontractors shall allow Contractor access to the Medical Records of its Members.

Exhibit A, Attachment 4
Quality Improvement System

6. Delegation of Quality Improvement Activities

A. Contractor is accountable for ~~Quality Improvement~~ **QI** functions and responsibilities even when it delegates ~~Quality Improvement~~ QI activities to its subcontractors. Contractor shall maintain a system to ensure accountability of delegated ~~Quality Improvement~~ **QI** activities including:

1) Maintenance of policies and procedures which describe: **(i)** delegated activities, **(ii)** ~~Quality Improvement~~ **QI** authority, function, and responsibility, **(iii)** how each **S**~~s~~ubcontractor shall be informed of its scope of ~~Quality Improvement~~ **QI** responsibilities, and **(iv)** ~~the~~ Subcontractor's accountability for delegated activities**;** ~~.~~

2) Establish reporting standards to include findings and actions taken by the ~~s~~**S**ubcontractor as a result of the ~~Quality Improvement~~ **QI** activities with the reporting frequency to be at least quarterly ~~.~~**;**

3) Maintenance of written procedures and documentation of continuous monitoring ~~and evaluation~~ of the delegated functions, evidence**ing** that the ~~actual~~ **q**~~Q~~uality of **c**~~C~~are being provided meets professionally**-**recognized standards**;** ~~.~~

4) Assurance and documentation that the Subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities ~~.~~**;**

5) Contractor shall approve the delegate's QIS, including its policies and procedures, which shall meet standards set forth by Contractor**; and** ~~.~~

6) Contractor shall ensure that the ~~actual~~ ~~Q~~**q**uality of ~~C~~**c**are being provided is ~~being~~ continuously monitored and evaluated.

B. Contractor shall implement and maintain ~~Quality Improvement~~ **QI** channels and facilitate coordination with other performance monitoring activities, including risk management and resolution and monitoring of Member **g**~~G~~rievances. Contractor's QIS shall maintain linkages with other management functions such as network changes, medical management systems (i.e. pre-certification), practice feedback to **p**~~P~~hysicians, patient education/health education, Member services, human resources feedback, and cultural and linguistic services feedback.

Exhibit A, Attachment 4
Quality Improvement System

7. Written Description

Contractor shall implement and maintain a written description of its QIS that shall include the following:

A. The organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.

B. The organizational chart ~~showing the~~ **evidencing** key staff and the committees and bodies responsible for ~~Quality Improvement~~ **QI** activities including reporting relationships of QIS committee(s) and staff within Contractor's organization.

C. The qualifications of staff responsible for ~~Quality Improvement~~ **QI** studies and activities, including education, experience**,** and training.

D. A description of the system for provider review of QIS findings, which**,** at a minimum, demonstrates Physician and other appropriate professional involvement and includes provisions for providing feedback to staff and providers~~,~~ regarding QIS study outcomes.

E. The role, structure, and function of the ~~Quality Improvement committee~~ **QIC**.

F. The processes and procedures designed to ensure that all **M**~~m~~edically **N**~~n~~ecessary **C**~~c~~overed **S**~~s~~ervices are available and accessible to all Members regardless of **sex,** race, color, national origin, creed, ancestry, **ethnic group identification,** religion, ~~language,~~ age, gender, marital status, sexual orientation, health status**, medical condition, mental disability,** ~~or~~ **physical** disability, **or genetic information** and that all Covered Services are provided in a culturally and linguistically appropriate manner.

G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that members are able to obtain appointments within established standard.

Exhibit A, Attachment 4
Quality Improvement System

H. A description of the quality of clinical care services provided, including, but not limited to, preventive services for adults, ~~P~~**p**rimary ~~C~~**c**are, specialty, emergency, inpatient, and ancillary care services.

I. A description of the activities, including activities used by Members that are ~~Seniors and Persons with Disabilities~~ **SPDs** or persons with chronic conditions, designed to assure the provision of **C**~~c~~ase **M**~~m~~anagement, coordination**,** and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services**,** and care management.

8. Quality Improvement Annual Report

Contractor shall develop an annual Quality Improvement **R**~~r~~eport **(QIR)** for submission to DHCS ~~by the end of each contractor's fiscal year~~ **on an annual basis**. The annual report shall include:

A. A comprehensive assessment of the ~~Quality Improvement~~ **QI** activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the ~~Quality Improvement~~ **QI** program~~,~~ including, but not limited to, the collection of aggregate data on utilization; the review of quality of services rendered; and, outcomes/findings from Quality Improvement ~~Systems~~ **Projects** (QI~~S~~**P**s), consumer satisfaction surveys**,** and collaborative initiatives.

B. Copies of all final reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA) relevant to Contractor's Medi-Cal line of business, including accreditation status and any deficiencies noted. **Including** the ~~Include the corrective action plan~~ **CAP, if any,** developed to address noted deficiencies.

C. An assessment of ~~s~~**S**ubcontractor's performance of delegated ~~Quality Improvement~~ **QI** activities.

9. Systematic Process of Quality Improvement

A. Contractor's QIS shall objectively and systematically monitor and evaluate the quality and appropriateness of care and services rendered on an ongoing basis. Contractor shall implement a QIS that addresses the quality of clinical care as well as the quality of health services delivery. Contractor shall ensure that the studies described below reflect the population served in terms of age groups, disease categories**,** and special

risk status. The QIS shall continuously monitor care against practice guidelines or clinical standards and shall use appropriate **q**~~Q~~uality ~~I~~**i**ndicators as measurable variables. Contractor shall ensure that **the** data collected shall be analyzed by the appropriate health professionals, and system issues shall be addressed by the Interdisciplinary Team (IDT). Contractor shall undertake corrective actions within the time frames determined by DHCS whenever problems are identified. Contractor shall maintain a system for tracking the issues over time to ensure that actions for improvement are effective.

B. Contractor shall perform **q**~~Q~~uality of **c**~~C~~are **s**~~S~~tudies on an ongoing basis as listed below:

1) Clinical Areas

a. Immunizations and health screens~~.~~

b. Adult preventive services~~.~~

2) Health Services Delivery Areas

a. Utilization of services~~.~~

b. Coordination of care~~.~~

c. Continuity of care~~.~~

d. Health education~~.~~

e. Emergency **s**~~S~~ervices~~.~~

f. Member satisfaction surveys~~.~~

g. Access to care~~.~~

C. Contractor shall use the following standards and guidelines for **a**~~A~~dult **p**~~P~~reventive **c**~~C~~are based on guidelines contained in the Report of the United States Preventive Services Task Force. For ~~Q~~**q**uality of ~~C~~**c**are studies in the health services delivery areas, Contractor shall use the specific standards set forth in the pertinent subsections. Contractor's Quality of Care studies may include health services delivery issues other than the priority areas identified. For other clinical or health services delivery areas where DHCS has not specified clinical standards or

practice guidelines, Contractor shall submit these standards or guidelines to DHCS for approval six weeks prior to conducting the studies.

D. To the extent feasible and appropriate, Contractor shall use the most recent Health Plan Employer Data and Information Set (HEDIS) indicators for the required **g**~~Q~~uality of **c**~~C~~are studies indicated in paragraph B~~, Quality of Care Studies~~.

10. Facility Review

A. Contractor shall conduct **f**~~F~~acility reviews on all **s**~~S~~ervice **s**~~S~~ites as part of the **c**~~C~~redentialing and recredentialing procedures. Facility reviews for **m**~~M~~edical **s**~~S~~pecialty **p**~~P~~rovider sites shall **also** be performed as follows:

1) Upon receipt by Contractor of any complaint received from a Member regarding a **m**~~M~~edical **s**~~S~~pecialty **p**~~P~~rovider**, after other means of communication (phone, email, etc.) have been unsuccessful for 10 business days**;

2) At the site of the **m**~~M~~edical **s**~~S~~pecialty **p**~~P~~rovider set forth in the Member complaint; and

3) Within 15 **business** days of receipt by Contractor of the complaint.

B. Facilities used by Contractor for providing **c**~~C~~overed **s**~~S~~ervices shall comply with all applicable federal and **s**~~S~~tate laws and regulations including, but not limited to, the provisions of Title 22, CCR, Section 53230.

C. Contractor shall ensure that its **f**~~F~~acility review procedures shall be submitted to DHCS for approval prior to use and shall comply with the current and/or revised requirements. These currently include the following categories:

1) Service and Provider Sites

a. Front office procedures including:

(1) Telephone access, triage, and advice~~.~~

(2) Appointment scheduling, as well as a system for coordinating interpreters for Limited English Proficient (LEP) Members~~.~~

(3) Missed appointment and follow-up~~.~~

(4) Referral appointment and follow-up~~.~~

(5) Referral (consultation) reports, lab and **x**~~X~~-ray follow-up~~.~~

b. Fire and disaster plan.

c. Infection control.

d. Handling of bio-hazardous wastes.

e. Health education.

f. Medical emergencies.

g. Pharmacy policies (including handling of sample drugs).

h. Medical Records storage and filing.

i. Medical Records documentation.

j. Grievances.

k. Laboratory services.

l. Radiological services.

m. Preventive services for adults.

n. Facility access for physically disabled individuals.

o. Informed consent procedures.

p. Linguistic services access.

2) Dental Provider Sites

Contractor shall develop, implement, and maintain a tool for monitoring dental providers and submit to DHCS for review and

approval. ~~Contractor may develop its own tool or use the tool provided by DHCS.~~

D. Contractor shall ensure that **f**~~F~~acility reviews are completed prior to new ~~Pace~~ **PACE** Centers expansion. Contractor shall submit the results of ~~Pace~~ **PACE** Centers expansion reviews to DHCS at least two weeks following the Licensing & Certification surveys and **f**~~F~~ire ~~Marshall~~ **marshal** clearance prior to plan or **s**~~S~~ervice **s**~~S~~ite operation. For ~~Pace~~ **PACE** Centers expansion reviews, Contractor shall submit an aggregate report of the review results.

E. Contractor shall provide any necessary assistance to DHCS in its conduct**ing** of **F**~~f~~acility inspections and medical reviews of the **q**~~Q~~uality of **c**~~C~~are being provided to Members. Contractor shall ensure correction of deficiencies as identified by those inspections and reviews according to the timeframes delineated by DHCS in the resulting reports.

F. Contractor shall ensure that sites with major, uncorrected deficiencies are not allowed to begin operation. Contractor shall take corrective action if a DHCS inspector finds a site to be in substantial non-compliance. Contractor shall require such site to cease providing services to Members~~;~~**,** provided that such site may not be required to cease providing services in the event DHCS and Contractor agree to a plan of corrective action to be implemented by the site, and such plan is being implemented to the satisfaction of DHCS.

G. Contractor shall remain responsible for the oversight and monitoring of delegated **f**~~F~~acility review activities.

11. Credentialing and Recredentialing

Contractor shall develop and maintain written policies and procedures that include initial **c**~~C~~redentialing, recredentialing, recertification, and reappointment of **p**~~P~~hysicians including Primary Care Physicians (PCP**s**) and specialists in accordance with ~~the MMCD, Credentialing and Recredentialing Policy Letter, MMCD Policy Letter 02-03~~ **DHCS All Plan Letter (APL) 19-004**. Contractor shall ensure ~~those~~ **the** policies and procedures are reviewed and approved by the governing body or designee. Contractor shall ensure the responsibility for recommendations regarding **c**~~C~~redentialing decisions will rest with a **c**~~C~~redentialing committee or other peer review body.

Exhibit A, Attachment 4
Quality Improvement System

A. Standards

All providers of **c**~~C~~overed **s**~~S~~ervices must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified**,** or registered. All providers must ~~have~~ **be in** good standing in the Medicare and Medicaid/Medi-Cal programs. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.

Contractor shall ensure that all contracted laboratory testing sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

B. Delegated Credentialing

Contractor may delegate **c**~~C~~redentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with provision 6. ~~Delegation of Quality Improvement Activities, above.~~

C. Credentialing Provider Organization Certification

Contractor and their subcontractors (e.g. a medical group or independent ~~physician~~ **Physician** organization) may obtain **c**~~C~~redentialing provider organization certification (POC) from the National Committee on Quality Assurance (NCQA). Contractor may accept evidence of **current** NCQA POC certification in lieu of a monitoring visit at delegated ~~Physician~~ **physician** organizations.

D. Disciplinary Actions

Contractor shall implement and maintain a system for ~~the~~ reporting ~~of~~ serious quality deficiencies that result in suspension or termination of a practitioner**,** to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including~~,~~ reducing, suspending**,** or terminating a practitioner's privileges. Contractor shall implement and maintain a **process for providers to appeal** ~~provider appeal process~~ **such disciplinary actions**.

E. Medi-Cal and Medicare Provider Status

Contractor will verify that their **S**~~s~~ubcontracted providers have not been terminated as Medi-Cal or Medicare providers or have not been placed on

the Suspended and Ineligible Provider list. Terminated providers in either Medicare or Medi-Cal/Medicaid or on the Suspended and Ineligible Provider list~~;~~ cannot participate in Contractor's provider network.

Contractor to follow the requirements set forth in APL 16-001 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-001.pdf

F. Health Plan Accreditation

If Contractor has received a rating of "Excellent**,**"~~,~~ "Commendable**,**" or "Accredited" from NCQA, Contractor shall be ~~"~~deemed~~"~~ to meet the DHCS requirements for **c**~~C~~redentialing and will be exempt from the DHCS medical review audit of **c**~~C~~redentialing.

Deeming of credentialing certification from other private credentialing organizations will be reviewed on an individual basis.

G. Credentialing of Other Non-Physician Medical Practitioners

Contractor shall develop and maintain policies and procedures that ensure that the credentials of **n**~~N~~urse **p**~~P~~ractitioners, **c**~~C~~linical **n**~~N~~urse **s**~~S~~pecialists and **p**~~P~~hysician ~~**Aa**~~**ssistants** have been verified in accordance with **s**~~S~~tate requirements **applicable to the provider category**.

12. ~~Member~~ Medical Records

A. General Requirement

~~Contractor shall maintain for each Member who has received medical services during enrollment, a legible Medical Record kept in detail consistent with good medical and professional practice which permits effective internal professional review and external medical audit processes and which facilitates an adequate system for follow-up treatment. Medical records shall be located at the Pace Centers the Member receives services and maintained in accordance with Title 22, CCR, Section 53284. Contractor shall ensure that appropriate Medical Records for the Member shall be available to all staff and health care providers at each Encounter.~~

Contractor shall ensure that appropriate medical records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4), Title 42 United States Code (USC) Section 1396a(w), 42 CFR 456.111 and 42

CFR 456.211, shall be available to health care providers at each encounter in accordance with Title 28, CCR Section 1300.67.1(c) and Title 22 CCR Section 53861, and Medi-Cal Managed Care Policy Letter 14-004.

B. Medical Records

Contractor shall develop, implement, and maintain written procedures pertaining to any form of **m**~~M~~edical **r**~~R~~ecords:

1) For storage and filing of **m**~~M~~edical **r**~~R~~ecords**,** including: collection, processing, maintenance, storage, retrieval identification, retention, and distribution**;** ~~.~~

2) To ensure **m**~~M~~edical **r**~~R~~ecords are protected and confidential in accordance with all federal and **s**~~S~~tate laws**;** ~~.~~.

3) For release of information and obtaining consent for treatment**;** ~~.~~ **and**

4) ~~To ensure maintenance of Medical Records in accordance with accepted professional standards. All entries must be legible, clear, complete, and appropriately authenticated and dated.~~ **To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copies).**

C. On-Site Medical Record

Contractor shall ensure that an individual ~~shall be~~ **is** delegated the responsibility of securing and maintaining **m**~~M~~edical **r**~~R~~ecords at each ~~Service~~ ~~S~~**s**ite.

D. Member Medical Record

Contractor shall ensure that a complete **m**~~M~~edical **r**~~R~~ecord is maintained for each Member in accordance with Title 22**,** ~~,~~CCR~~,~~ Section 53284, ~~located at the Pace Centers where the Member receives services~~ that reflects all aspects of patient care, including ancillary services**, and at a minimum includes:** ~~. Each Medical Record shall at a minimum include all requirements for Member Medical Records, as outlined in the federal PACE regulations 42 CFR, Section 460.210 (a)-(d), as well as the following provisions:~~

Exhibit A, Attachment 4
Quality Improvement System

1) Member identification on each page**, with**~~,~~ personal **and/or** biographical data in the record.

2) The identity of the Member's PCP.

3) All entries dated and author identified~~; by first initial, last name and title.~~ For Member visits, the entries shall include, at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.

4) The record shall contain a problem list, a current medications list, a complete record of immunizations**,** and health maintenance or preventive services rendered.

5) Allergies and adverse reactions are prominently noted in the record.

6) All informed consent documentation, including the human sterilization consent procedures required by Title 22~~,~~ CCR~~,~~ Sections 51305.1 through 51305.6, if applicable.

7) Reports of emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions ~~while the patient is enrolled~~.

8) Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.

9) Documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.

10) Member's preferred language (if other than English) **or use of auxiliary aids and services for effective communication (Members with disabilities),** prominently noted in the record as well as the request or refusal of language **and/or** interpretation services**; and**~~.~~

11) Health education behavioral assessment and referrals to health education services.

Exhibit A, Attachment 4
Quality Improvement System

E. Contractor shall implement and maintain a system to review records for compliance with Medical Records standards, and institute a Corrective Action Plan when necessary. Contractor shall ensure that Medical Records shall be reviewed for:

1) ~~U~~**u**niformity of forms~~.~~**;**

2) ~~L~~**l**egibility (the record is legible to a person other than the writer)~~.~~**;**

3) ~~C~~**c**ompleteness~~.~~**;**

4) ~~Q~~**q**uality and appropriateness of services provided~~.~~**;**

5) ~~I~~**i**mmunizations~~.~~**;**

6) ~~P~~**p**reventive health screening~~.~~**; and**

7) ~~A~~**a**uthentication.

13. Laboratory Certification

A. To ensure that each laboratory used to perform services under this Contract or by subcontract complies with federal and State law, each location at which any test or examination on materials derived from the human body for the purpose of providing information for the diagnosis, prevention, treatment or assessment of any disease, impairment or health of a human being is performed shall have in effect:

1) A current, unrevoked or unsuspended certificate, certificate for provider-performed microscopy procedures, certificate of accreditation, certificate of registration or certificate of waiver issued under the requirements of 42 United States Code, Section 263a and the regulations adopted thereunder and found at 42 CFR, Part 493; and, either

a. A current, unrevoked or unsuspended license or registration issued under the requirements of Chapter 3 (commencing with Section 1200) of Division 2 of the California Business and Professions Code and the regulations adopted thereunder; or,

b. Be operated in conformity with Chapter 7 (commencing with Section 1000) of Division 1 of the California Health and Safety Code and the regulations adopted thereunder.

B. All places used to perform tests or examinations on human biological specimens (materials derived from the human body) are, by definition, "laboratories" under federal and ~~S~~**s**tate law.

C. Laboratories may exist, therefore, at ~~N~~**n**urses' stations within hospitals, clinics, ~~S~~**s**killed ~~N~~**n**ursing ~~F~~**f**acilities, operating rooms, surgical centers, ~~r~~**R**ural ~~h~~**H**ealth ~~c~~**C**linics **(RHCS)**, Physician offices, Planned Parenthood clinics, mobile labs, health fairs, and city, county or State labs.

D. Any laboratory that does not comply with ~~the~~ appropriate federal and State law is not eligible for participation in, or reimbursement from, the Medicare, Medicaid**,** or Medi-Cal programs.

E. Member Dental Records

Contractor shall maintain a complete dental record and implement a system to review dental records, which at a minimum shall include:

1) Legible, organized, appropriately signed records.

a. Complete records with detailed findings;

b. Signed general and informed consent forms ;and

c. Complete treatment plan.

2) A medical history, current medications, allergies, and medical clearance if necessary.

Exhibit A, Attachment 5
Utilization Management

1. Utilization Management (UM) Program

Contractor shall develop, implement, and ~~maintain~~ **continually update and improve** a ~~Utilization Management (~~UM~~)~~ program which ~~includes a list of services that require Prior Authorization, persons responsible for UM and their qualifications, procedures to evaluate Medical Necessity, criteria used for approval, referral, and Denial of services, information sources, and the process used to review and approve the provision of Medically Necessary Covered Services.~~ **ensures appropriate processes are used to review and approve the provision of medically necessary covered services. Contractor is responsible to ensure that the UM program includes:**

A. Qualified staff who are responsible for the UM program.

B. The separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management. Compensation of staff or Subcontractors that conduct UM activities shall not be structured to provide incentives to deny, limit, or discontinue Medically Necessary services.

C. Contractor shall ensure that the UM program allows for a second opinion from a qualified health professional at no cost to the Member.

D. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of the specific criteria used by the Contractor.

E. Contractor shall communicate to health care practitioners the procedures and services that require Prior Authorization and ensure that all contracting health care practitioners are aware of the procedures and timeframes necessary to obtain Prior Authorization for these services.

F. An established specialty referral system to track and monitor referrals requiring Prior Authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness for the referrals. This specialty referral system should include non-contracting providers.

Contractor shall ensure that all contracting health care practitioners are aware of the referral processes and tracking procedures; and.

G. The integration of UM activities into the QIS, including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff.

These activities shall be done in accordance with Health and Safety Code section 1363.5 and California Code of Regulations, title 28, section 1300.70, subdivisions (b)(2)(H) & (c).

2. ~~Pre~~Prior-Authorization and Review Procedures

Contractor shall ensure that its ~~pre~~**prior**-authorization**,** ~~and~~ concurrent review**, and retrospective review** procedures ~~shall~~ meet the following minimum requirements:

A. **Consult with the requesting Provider for medical services, when appropriate.**

Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the medical or behavioral health condition or disease. Appropriate clinical expertise may be demonstrated by appropriate specialty training, experience, or certification by the American Board of Medical Specialties. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions.

~~A~~**B**. Qualified health care professionals supervise review decisions, including service reductions, and a qualified Physician will review all denials that are made, **in** whole or in part, on the basis of **M**~~m~~edical **N**~~n~~ecessity. For purposes of this provision, a qualified ~~P~~**p**hysician or Contractor's ~~P~~**p**harmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of**,** and pursuant to**,** criteria established by ~~the Plan~~ **Contractor's** ~~M~~**m**edical ~~D~~**d**irector~~, in collaboration with the Plan Pharmacy and Therapeutics Committee (PTC) or its equivalent~~.

Exhibit A, Attachment 5
Utilization Management

~~B~~**C**. There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is ~~updated regularly and~~ consistently applied**, regularly reviewed, and updated**.

~~C~~**D**. **The r**~~R~~easons for decisions are clearly documented.

~~D~~**E**. ~~There is a well-publicized Appeals procedure for both providers and Members.~~
Notification to Members regarding denied, deferred or modified referrals is made as specified in Exhibit A, Attachment 13. There shall be a well-publicized appeals procedure for both providers and patients.

~~E~~**F**. Decisions and appeals are made in a timely manner **and are not unduly delayed for medical conditions requiring time-sensitive services**.

G. Prior Authorization requirements shall not be applied to emergency services, preventive services, sexually transmitted disease services, and HIV testing.

H. Records, including any notice of action (NOA), shall meet the retention requirements described in Exhibit E, Attachment 2, provision 19, Audit.

I. Contractor must notify the requesting provider or Member of any decision to deny, approve, modify, or delay a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be provided orally or in writing. Notice to the member shall be in writing and in accordance with the requirements in Exhibit A, Attachment 13, Member Services, Provision 6, Denial, Deferral, or Modification of Prior Authorization Requests.

~~Contractor shall ensure that Prior Authorization requirements are not applied to Emergency Services, preventive services, and Sensitive Services.~~

3. Timeframes and Medical Authorization

A. Emergency Care & Post-Stabilization: contractor must comply with the timeframes and authorization procedures set forth in 42 CFR 460.100, which are set forth in Exhibit A, Attachment 8, Provision 11.

Exhibit A, Attachment 5
Utilization Management

B. Non-urgent care following an exam in the emergency room: response to request within one hour or it will be deemed approved.

C. Concurrent review of authorization for treatment regimen already in place: within five working days or less, consistent with the urgency of the Member's medical condition and in accordance with Health and Safety Code section 1367.01(h)(3), or any future amendments thereto.

D. Retrospective review: within 30 calendar days in accordance with Health and Safety Code section 1367.01(h)(1), or any future amendments thereto.

E. Pharmaceuticals: for all covered outpatient drug Prior Authorization requests, provide notice by telephone, fax, email or other electronic communication within 24 hours of receipt of the request, and in emergency situations dispense at least a 72-hour supply of the covered outpatient drug in accordance with Welfare and Institutions Code section 14185, 42 CFR 438.3(s)(6), and Section 1927(d)(5)(A) of the Social Security Act or any future respective amendments thereto.

F. Routine Authorizations: within five working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from Prior Authorization) in accordance with Health and Safety Code, section 1367.01, or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the state for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

G. Expedited Authorizations: For requests in which a provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and not later than 72 hours after receipt of the request for services. The Contractor may extend the three working days time

period by up to 14 calendar days if the Member requests an extension, or if the Contractor justifies to satisfaction of DHCS the need for additional information and how the extension is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

H. Hospice Inpatient Care: 24-hour response.

~~3~~4. Review of Utilization Data

Contractor shall ~~ensure that~~ **include within** the UM program ~~has~~ mechanisms to detect both under and over-utilization of **health care** services. **Contractor's internal reporting mechanisms used to detect member utilization patterns shall be reported to DHCS upon request.**

~~4~~5. Delegating UM Activities

Contractor ~~shall ensure that~~ **may** delegate~~d~~ UM activities**.** ~~to Subcontractors are approved and regularly evaluated. Contractor shall ensure that this process is documented~~. **If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6**.

Exhibit A, Attachment 6
Provider Network

1. Network Composition

Contractor shall demonstrate the continuous availability and accessibility of adequate numbers of institutional **f**~~F~~acilities, **s**~~S~~ervice **l**~~L~~ocations, **s**~~S~~ervice ~~S~~**s**ites, and professional, allied, and supportive paramedical personnel and providers to provide **c**~~C~~overed **s**~~S~~ervices including the provision of all medical care necessary under emergency circumstances on a 24 hour, seven day**s**-**per** ~~a~~-week basis.

Contractor shall ensure and monitor an appropriate provider network, including PCPs, specialists, professional, allied, supportive paramedical personnel, and an adequate number of accessible inpatient facilities and PACE Centers within each service area.

2. Provider to Member Ratios

Contractor shall ensure ~~the~~ **that** network**s continuously** ~~is sufficient to~~ satisfy the following full-time equivalent provider to Member ratios:
One full-time equivalent ~~Primary Care Physician (~~PCP~~)~~ per 350 Members.

3. Physician Supervisor to Non-Physician Medical Practitioner Ratios

Contractor shall ensure compliance with Title 22**,** ~~:~~ CCR**,** Sections 51240 and 51241, and that full time equivalent **p**~~P~~hysician **s**~~S~~upervisor to **n**~~N~~on-**p**~~P~~hysician **m**~~M~~edical **p**~~P~~ractitioner ratios at PACE ~~Service Sites~~**Centers** do not exceed the following:

A. ~~N~~**n**urse practitioners 1:4

B. ~~P~~**p**hysician assistants 1:2

C. ~~F~~**f**our ~~(4)~~ ~~N~~**n**on-~~P~~**p**hysician ~~M~~**m**edical ~~P~~**p**ractitioners in any combination that does not include more than two ~~(2)~~ physician assistants.

4. Emergency Services

Contractor shall have, as a minimum, a designated emergency service facility, providing care on a 24 hours a day, seven days-per-week basis. This designated emergency service facility will have one or more Physicians and one or more nurses on duty in the facility at all times.

Exhibit A, Attachment 6
Provider Network

45. Specialists

Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care **in accordance with Welfare and Institutions Code section 14182(c), criteria (2)**. Contractor shall provide a recording/tracking mechanism for each authorized, **d**~~D~~enied**,** or modified referral. In addition, Contractor shall offer second opinions by ~~S~~**s**pecialists to any Member upon request.

6. Federally Qualified Health Center (FQHC) Services

Contractor shall meet federal requirements for access to FQHC services, including those in 42 United States Code section 1396b(m). Contractor shall reimburse FQHCs in accordance with Exhibit A, Attachment 8, Provision 7.

57. Physician Services

~~Contractor shall provide Physician services:~~
Contractor shall provide physician services ~~D~~**d**irectly through ~~P~~**p**hysicians who are employees of Contractor or who have agreements with Contractor to provide health care services or **who** are providers of ~~U~~**u**nusual or ~~S~~**s**eldom-~~U~~**u**sed ~~H~~**h**ealth ~~C~~**c**are ~~S~~**s**ervices as defined by DHCS.

68. Continuity of Care

Contractor shall establish and operate a system to assure continuity of care through appropriate referral of Members needing specialty health care services, documentation of referral services in Member ~~M~~**m**edical ~~R~~**r**ecords, monitoring of Members with ongoing medical conditions, documentation of Member emergency medical encounters in ~~M~~**m**edical ~~R~~**r**ecords, with appropriate follow-up as medically indicated, and coordinated hospital discharge planning that includes necessary post-discharge care.

79. Emergency Management Plan

Contractor shall maintain an emergency management plan~~,~~ **in compliance with 42 CFR 460.84, including a** response and recovery approach that provides ~~a process~~ for **the** ~~mitigating~~ **mitigation**, ~~responding~~ **response** to, and ~~recovering~~ **recovery** from an emergency.

Exhibit A, Attachment 6
Provider Network

~~8~~10. Plan Physician Availability

Contractor shall have a plan or contracting ~~P~~**ph**ysician available 24 hours per day, seven days per week to coordinate the transfer of care of a Member whose emergency condition is stabilized, to authorize Medically Necessary post-stabilization services, and for general communication with emergency room personnel.

~~9~~11. Plan Subcontractors

Contractor shall submit to DHCS~~, in accordance with PACE Policy Letter 03-01~~, a quarterly updated subcontractor listing, which, at a minimum, contains the following information:

A. Headers to indicate city or region names (in alphabetical order)**;**

B. Specialty (e.g. Optometry)**;**

C. Provider's name (last, first-listed alphabetically)**;**

D. Street address**;**

E. City including zip codes**;**

F. Telephone number including area code**;**

G. Languages (other than English) spoken at the provider site**; and**

H. Medical Group/Institutional/Specialty name (e.g. University of California)**.**

Contractor shall notify DHCS in the event the agreement with the Subcontractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

~~10~~12. Ethnic and Cultural Composition

Contractor shall ~~make all due diligence to~~ ensure that the composition of Contractor's provider network meets the ethnic, cultural, and linguistic needs of Contractor's Members on a continuous basis.

~~11~~13. Subcontract**s** ~~Requirements~~

Exhibit A, Attachment 6
Provider Network

Contractor may ~~elect to~~ enter into **s**~~S~~ubcontracts with other entities in order to fulfill the obligations of the Contract. ~~In doing so, Contractor shall meet the subcontracting requirements as stated in Title 22, CCR, Section 53250 and this Contract~~. **Contractor shall evaluate the prospective Subcontractor's ability to perform the subcontracted services, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements as stated in 42 CFR 460.70(a), (b), (c), and (d).**

A. Subcontract **Requirements**

Each **s**~~S~~ubcontract **as defined in Exhibit E, Attachment 1,** shall contain:

1) Specification of the services to be provided by the ~~s~~**S**ubcontractor~~.~~**;**

2) Specification that the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing this Contract~~.~~**;**

3) Specification that the Subcontract or Subcontract amendments shall become effective only as set forth in paragraph ~~B~~**C** ~~Departmental Approval, of this provision.~~**;**

4) Specification of the term of the Subcontract, including the beginning and ending dates as well as methods of extension, renegotiation, and termination~~.~~**;**

5) Language comparable to Exhibit A, Attachment 8, provision 7 for those Subcontractors at risk for non-contracting emergency services;

~~5~~**6**) Subcontractor's agreement to submit reports as required by Contractor~~.~~**;**

7) Specification that the Subcontractor shall comply with all monitoring provisions of this Contract and any monitoring requests by DHCS;

~~6~~**8**) Subcontractor's agreement to make all of its **premises, facilities, equipment**, books**,** ~~and~~ records**, contracts, computer and other electronic systems** pertaining to the goods and services furnished under the terms of the subcontract, available for **the purpose of an audit, evaluation,** inspection, examination**,** or copying**, including**

but not limited to access requirements and state's right to monitor, as set forth in Exhibit E, Attachment 2, provision 20:

a. By DHCS, **CMS,** Department of Health and Human Services (DHHS), and Department of Justice (DOJ)**, DMHC or their designees**.

b. At all reasonable times at the **S**~~s~~ubcontractor's place of business or at such other mutually agreeable location in California.

c. In a form maintained in accordance with the general standards applicable to such book or record keeping.

d. For a term of at least ~~six (6)~~ **ten** years from the close of ~~DHCS'~~ **the current** fiscal year in which the ~~Subcontract was in effect~~ **service occurred; in which the record or data was created or applied; and for which the financial record was created**.

e. Including all ~~E~~**e**ncounter data for a period of at least ~~six(6)~~ **ten** year**s**.

f. If DHCS, CMS, or the Department of Health and Human Services (DHHS) Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time, and

g. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Subcontractor from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor.

~~7~~**9**) Full disclosure of the method and amount of compensation or other consideration to be received by the S~~s~~ubcontractor from Contractor.

~~8~~**10**) Subcontractor's agreement to maintain and **to** make available to DHCS, upon request, copies of all **S**~~s~~ub-**S**~~s~~ubcontracts and to ensure that all **S**~~s~~ub-**S**~~s~~ubcontracts are in writing and require that the ~~Sub-~~Subcontractor:

a. Make all **premises, facilities, equipment,** applicable books and records, **contracts, computer, or other electronic systems related to this Contract**, available at all reasonable times for **audit,** inspection, examination or copying by DHCS, DHHS,**CMS,** ~~and~~ DOJ**, or their designees.**

b. ~~Retain such books and records for a term of at least six (6) years from the close of DHCS' fiscal year in which the sub-contract is in effect.~~
Retain all records and documents for a minimum of ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

~~9~~**11**) Subcontractor's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, provision 15~~.~~ B~~.~~ ~~Phase-out Requirements~~, **subparagraph B** in the event of Contract termination.

12) Subcontractor's agreement to assist Contractor and DHCS in the transfer of care in the event of Sub-contract termination for any reason.

~~10~~**13**) Subcontractor's agreement that assignment or delegation of the ~~S~~**s**ubcontract shall be void unless prior written approval is obtained from DHCS.

~~11~~**14**) Subcontractor's agreement to hold harmless both the ~~S~~**s**tate and Members in the event Contractor cannot or ~~shall~~ **will** not pay for services performed by the ~~s~~**S**ubcontractor pursuant to the ~~S~~**s**ubcontract.

~~12~~**15**) Subcontractor's agreement to timely gather, preserve and provide to DHCS, any records in the ~~s~~**S**ubcontractor's possession, in accordance with Exhibit E, Attachment 2, provision 25. ~~Records Related to Recovery for Litigation~~.

~~13~~**16**) subcontractor's agreement to provide interpreter services for Members at all ~~Service Sites and Service Locations~~ **provider sites.**

Exhibit A, Attachment 6
Provider Network

~~14~~**17**) Subcontractor's right to submit a~~n Appeal~~ **grievance** and Contractor's formal process to resolve **p**~~P~~rovider ~~Appeals~~ **grievances**.

~~15~~**18**) Subcontractor's agreement to participate and cooperate in Contractor's ~~Quality Improvement System~~ **QIS**.

~~16~~**19**) If Contractor delegates ~~Quality Improvement~~ **QI** activities, **s**~~S~~ubcontract shall include those provisions stipulated in Exhibit A, Attachment 4, provision 6~~. Delegation of Quality Improvement Activities~~**; and**

~~17~~**20**) Subcontractor's agreement to comply with all applicable requirements of ~~the~~ DHCS, Medi-Cal Managed Care Program**,** and the ~~Long-Term Care Division (LTCD)~~ **Integrated Systems of Care Division (ISCD)**.

B. Department Approval

1) **Except as provided in Exhibit A, Attachment 8, provision 7, regarding FQHCs and RHCS, a** provider ~~S~~**s**ubcontract entered into by a Contractor **which is not a federally qualified HMO** shall become effective upon approval by DHCS in writing or by operation of law where DHCS has acknowledged receipt of the proposed ~~S~~**s**ubcontract, and has failed to approve or disapprove the proposed ~~S~~**s**ubcontract within sixty (60) days of receipt. Within five (5) State working days of receipt, DHCS shall acknowledge verbally or in writing the receipt of any material sent to DHCS by Contractor for approval.

2) Subcontract amendments shall be submitted to DHCS for prior approval at least ~~thirty (~~30~~)~~ **calendar** days before the effective date of any proposed changes governing compensation, services or term. Proposed changes which are neither approved or disapproved by DHCS, shall become effective by operation of law ~~thirty (~~30~~)~~ **calendar** days after DHCS has acknowledged receipt or upon the date specified in the ~~S~~**s**ubcontract amendment, whichever is later.

3) Whenever contractor submits a subcontract or amendment to a subcontract to DHCS, contractor must identify where specifically in the subcontract each requirement of 42 CFR 460.70(a), (b), (c), and (d) are met.

C. Public Records

Subcontracts entered into by Contractor**,** and all information received in accordance with this subsection**,** will be public records on file with DHCS, except as specifically exempted in statute. DHCS shall ensure the confidentiality of information and contractual provisions filed with DHCS to the extent they are specifically exempted by statute from disclosure, in accordance with the statutes providing the exemption. The names of the officers and owners of the ~~s~~**S**ubcontractor, stockholders owning more than ~~ten (10)~~ **5** percent of the stock issued by the ~~s~~**S**ubcontractor**,** and major creditors holding more than ~~five (~~5~~)~~ percent of the **Subcontractor's** debt ~~of the subcontractor~~ will be attached to the ~~S~~**s**ubcontract at the time ~~the Subcontract~~ **it** is presented to DHCS.

~~12~~14. Restrictions on Delegation

Existing and applicant **PACE Organizations (**POs)~~'s~~ are not allowed to delegate to a separate entity the operation of an existing or additional (expansion) PACE Center and IDT. DHCS reserves the right to determine whether a PO delegation arrangement involves a separate entity. If DHCS determines that the delegation arrangement involves a separate entity, DHCS may terminate the contract or take other appropriate action, including but not limited to requiring the PO to comply with a ~~corrective action plan~~ **CAP**. PO**'**s may subcontract for the provision of **member** ~~participant~~ service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a **member** ~~participant~~ safely in their home/community are available to the **member** ~~participant~~.

The only exception to the prohibition on the delegation of PACE Center and IDT operations is the On Lok delegation contract with the Institute of Aging originally established on August 1, 1996.

The prohibition on delegation does not prohibit a PO from utilizing alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the **member** ~~participant's~~ home, an inpatient facility, or PACE Center. A PACE **member** ~~participant~~ may receive some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center, and all PACE **members** ~~participants~~ receiving services at an ACS must be assigned to a PACE Center and IDT.

Exhibit A, Attachment 6
Provider Network

15. Subcontracts with Federally Qualified Health Centers and Rural Health Clinics

Subcontracts with FQHCs shall also meet Subcontract requirements of provision 13 above and reimbursement requirements in Exhibit A, Attachment 8, provision 7.

~~13~~16. Nondiscrimination in Provider Contracts

Contractor shall not discriminate for the participation, reimbursement**,** or indemnification of any provider who is acting within the scope of practice of his or her license or certification under applicable ~~S~~**s**tate law~~,~~ solely on the basis of that license or certification. If Contractor declines to include **an** individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. Contractor's provider selection policies must not discriminate against providers that serve high-risk populations or specialize in conditions requiring costly treatment. This section shall not be construed to require Contractor to contract with providers beyond the number necessary to meet the needs of Contractor's Members; preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with Contractor's responsibilities to Members.

Exhibit A, Attachment 7
Provider Relations

1. Exclusivity

Contractor shall not, by use of an exclusivity provision, clause, agreement or in any other manner, prohibit any ~~s~~**S**ubcontractor from providing services to Medi-Cal beneficiaries who are not Members of Contractor's plan. This prohibition is not applicable to contracts entered into between Contractor and Knox-Keene licensed health care plans.

2. Provider Appeals

Contractor shall have a formal process to accept, acknowledge, and resolve Provider Appeals. A provider of medical services may submit to Contractor an Appeal concerning the authorization or denial of a service; denial, deferral or modification of a Prior Authorization request on behalf of a Member; or the processing of a payment or non-payment of a claim by the Contractor. This process shall be communicated to all contracting**, subcontracting, and non-contracting** providers ~~whose claim has been denied~~.

Contractor shall implement and maintain procedures to monitor Providers' Appeals, which shall include*:*

A. A procedure to ensure timely resolution and feedback to provider. Contractor shall acknowledge receipt of the Appeal within five days and resolve the Appeal within 30 days or document reasonable efforts to resolve the Appeal.

B. A procedure for systematic aggregation and analysis of the Appeals data and use for Quality Improvement.

C. A procedure to ensure that the Appeal submitted is reported to an appropriate level, i.e., payment or administrative issues versus medical or health care delivery issues.

3. Non-Contracting, Non-Emergency Provider Communication

Contractor shall develop and maintain protocols for payment of claims, and communicating and interacting with non-contracting, non-emergency providers.

4. Provider Manual

Contractor shall issue a ~~P~~**p**rovider ~~M~~**m**anual and updates to **the contracting and subcontracting** providers of ~~C~~**c**overed ~~S~~**s**ervices. ~~The manual shall serve as a source of information to health care providers and shall include, but is not limited~~

~~to, information on Contractor's program, Member and Provider Grievances and Appeals and Contractor's Quality Improvement System (QIS).~~ **That includes information and updates regarding covered services, policies and procedures, statutes, regulations, telephone access, special requirements, and the Member grievance, appeal, and State Hearing process. The Contractor's provider manual shall include the following Member rights information:**

A. member's right to a State Hearing, how to obtain a hearing, and representation rules at a State Hearing;

B. member's right to file Grievances and Appeals as well as their requirements and timeframes for filing;

C. availability of assistance in filing;

D. toll-free numbers to file oral Grievances and Appeals; and

E. member's right to request continuation of benefits during an appeal or State Hearing.

5. Provider Training

A. Contractor shall ensure that all Providers receive ~~information or~~ training regarding the PACE program in order to operate in full compliance with the Contract and all applicable federal and ~~S~~**s**tate statutes and regulations. Contractor shall ensure that Provider ~~information or~~ training relates to PACE services, policies, procedures**,** and any modifications to existing services, policies**,** or procedures. **Training shall include methods for sharing information between Contractor, Provider, Member and/or other healthcare professionals.** Contractor shall conduct training ~~or provide information~~ for all providers ~~within ten (10) working days after Contractor places a newly contracted Provider on active status~~ **prior to commencement of Provider service with participant**. Contractor shall ensure that Provider ~~information or~~ training includes information on all Member rights specified in Exhibit A, Attachment 13, ~~Member Services,~~ including the right to full disclosure of health care information and the right to actively participate in health care decisions. Contractor shall ensure that ongoing ~~information or~~ training is ~~provided~~ **conducted** when deemed necessary by either the Contractor or the ~~S~~**s**tate.

Exhibit A, Attachment 7
Provider Relations

B. Contractor shall develop and implement a process to provide information to providers and to train Providers on a continuing basis regarding clinical protocols, evidenced-based practice guidelines and DHCS-developed cultural awareness and sensitivity instruction for SPDs or persons with or chronic conditions. This process shall include an educational program for Providers regarding health needs specific to this population that utilizes a variety of educational strategies, including but not limited to, posting information on websites as well as other methods of educational outreach to Providers.

6. Emergency Preparedness

A. Contractor shall establish and annually update an emergency preparedness program that meets all ~~F~~**f**ederal, ~~S~~**s**tate and local emergency preparedness requirements and complies with **42 CFR** ~~Section~~ 460.84 ~~of Title 42 of the Code of Federal Regulations (hereafter referred to as 42 C.F.R. § 460.84)~~. Without limitation, Contractor shall do all of the following:

1) Contractor shall develop and annually update an emergency preparedness plan, in compliance with 42 C~~.~~F~~.~~R~~.~~ ~~§~~ 460.84(a), that is based on a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.

2) Contractor shall develop and annually update documented policies and procedures, in compliance with 42 C~~.~~F~~.~~R~~.~~ ~~§~~ 460.84(b), to manage medical and nonmedical emergencies and disasters identified in its emergency plan.

3) Contractor shall ensure that unexpired food, water, medical supplies, and functioning emergency equipment, including easily portable oxygen, airways, suction, and emergency drugs, along with employees who know how to use the equipment, are on the premise of every ~~S~~**s**ervice ~~S~~**s**ite at all times and readily available.

4) Contractor shall develop and annually update a communication plan in compliance with 42 C~~.~~F~~.~~R~~.~~ ~~§~~ 460.84(c).

5) Contractor shall provide initial and annual emergency preparedness training and orientation to all its employees, contracted providers, Members, and others, as required by 42 C~~.~~F~~.~~R~~.~~ ~~§~~ 460.84(d), and shall ensure that staff demonstrate a knowledge of emergency

procedures, including informing Members what to do, where to go, and whom to contact in case of an emergency. Contractor shall maintain documentation of all training**; and**.

6) Contractor shall conduct exercises to test, evaluate, and document the effectiveness of its emergency plan at least annually, in compliance with 42 C.F.R. § 460.84(d).

B. If Contractor is part of a health care system consisting of multiple separately certified health care facilities that elect to have a unified and integrated emergency preparedness program, Contractor must ensure compliance with 42 C.F.R. § 460.84(e).

C. Protocols shall be distributed to all Contractor's employees and contracted providers in the Sservice Aarea and shall include, at a minimum, the following:

1) Ddescription of telephone access, triage, and advice systems used by Contractor.;

2) Aa plan contact person or an on-call provider responsible for coordinating services that can be accessed 24 hours per day.:

3) Pprocess for rapid interfacing with emergency care systems.**; and**

4) Rreferral procedures (including after-hours instructions) which emergency department personnel can provide to Medi-Cal Members who present at the **an** emergency department for non-emergency services.

D. Contractor shall ensure that the federal government, State, and Members are held harmless if Contractor does not pay for emergency services.

E. Contractor shall test, evaluate, and document the effectiveness of its emergency and disaster plans at least annually.

F. Contractor shall ensure that the federal government, State, and Members are held harmless if Contractor does not pay for emergency services.

7. Prohibited Punitive Action Against the Provider

Contractor must ensure that punitive action is not taken against the **a** provider who either requests an expedited resolution to a Provider's Appeal or supports a

Exhibit A, Attachment 7
Provider Relations

Member's Appeal. Further, Contract may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient~~:~~**,** for the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, for any information the enrollee needs in order to decide among all relevant treatment options, for the risks, benefits, and consequences of treatment or non-treatment, for the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decision**s**.

Exhibit A, Attachment 8
Provider Compensation Arrangements

1. Compensation

~~Contractor shall not enter into any Subcontract if the compensation or other consideration which the subcontractor shall receive under the terms of the Subcontract is determined by a percentage of Contractor's payment from DHCS.~~ **Contractor may compensate providers as Contractor and provider negotiate and agree. Unless DHCS objects, compensation may be determined by a percentage of the Contractor's payment from DHCS.** This ~~subsection~~ **provision** shall not be construed to prohibit Subcontracts in which compensation or other consideration is determined **to be** on a Capitation basis.

2. Physician Incentive Plan Requirements

Contractor may implement and maintain a ~~P~~**p**hysician **i**ncentive ~~P~~**p**lan only if~~:~~ **no specific payment is made directly or indirectly under the incentive plan to a physician or physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member**

~~A. No specific payment is made directly or indirectly under the incentive plan to a Physician or Physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member; and~~

~~B. The stop-loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR, Section 417.479 are met by Contractor.~~

3. Claims Processing

Contractor shall pay all claims submitted by subcontracting providers in accordance with this section, unless the subcontracting provider and Contractor have agreed in writing to an alternate payment schedule.

A. **C**ontractor shall comply with Section 1932(f)~~,~~ **of** Title XIX~~,~~ **of the** Social Security Act (42 U.S.C. Section 1396u-2(f)), and Health and Safety Code, Section**s** 1371 **through 1371.36.**~~,~~ ~~subject to the following:~~ **Contractor shall be subject to any remedies, including interest payments provided for in these sections, if it fails to meet the standards specific in these sections.**

~~1)~~**B.** Contractor shall pay ~~or deny~~ 90% of **Complete** ~~c~~**C**laims **from practitioners who are in individual or group practices or who participate in health facilities,** ~~for payment submitted by providers for which no further written documentation or substantiation is required~~ within

30 days of **the date of** receipt**, or payment by agreed terms of contract, and 99 percent of all Complete Claims within 90 days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment** ~~by Contractor. Written notice must be given to providers of contested claims within 30 days after receipt of the claim by Contractor. Such notice shall state the reason(s) for contesting the claim. Contractor agrees that failure to provide timely notification to a provider of a contested claim means that the claim is not being contested and is subject to the requirements for paying uncontested claims~~.

~~2) Contractor shall ensure that 100% of claims for payment submitted by providers for which no further written documentation or substantiation is required are paid or denied within 45 State working days after receipt~~.

~~B~~**C**. Contractor shall maintain procedures for pre**-**payment and post**-**payment claims review, including review of data related to provider, Member and Covered Services for which payment is claimed.

~~C~~**D**. Contractor shall maintain sufficient claims processing/tracking/payment systems capability to**:** comply with applicable federal and ~~S~~**s**tate law and regulations **and Contract requirements, determine the status of received claims, and calculate the estimate for incurred and unreported claims, as specified by Title 28, CCR, Sections 1300.77.1 and 1300.77.2.**

4. Prohibited Claims

A. Except in specified circumstances, Contractor and any of its ~~A~~**a**ffiliates and subcontractors shall not submit a claim or demand, or otherwise collect reimbursement for any services provided under this Contract to a **Medi-Cal** Member. Collection of claim may be made under those circumstances described in **Welfare and Institutions Code section 14452.6,** Title 22, CCR, ~~S~~**s**ections ~~53866,~~ 53220, and 53222.

B. Contractor shall not hold Members liable for Contractor's debt if Contractor becomes insolvent. In the event Contractor becomes insolvent, Contractor shall cover continuation of services to Members for the duration of the period for which payment has been made, as well as for inpatient admissions up until discharge.

Exhibit A, Attachment 8
Provider Compensation Arrangements

5. Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Programs

A. FQHCs Availability and Reimbursement Requirement

If FQHC or RHC services are not available in the Contractor's provider network Contractor shall reimburse non-contracting FQHCs and RHCs for services provided to Contractor's Members at a level and amount of payment that is not less than the Contractor makes for the same scope of services furnished by a provider that is not a FQHC or RHC.

B. Federally Qualified Health Centers/Rural Health Clinics (FQHC/RHC)

Contractor shall submit to DHCS, within 30 calendar days of a request and in the form and manner specified by DHCS, the services provided and the reimbursement level and amount for each of Contractor's FQHC and RHC Subcontracts. Contractor shall certify in writing to DHCS within 30 calendar days of DHCS' written request that, pursuant to Welfare and Institutions Code Section 14087.325(b) and (d), as amended by Chapter 894, Statutes of 1998, FQHC and RHC Subcontract terms and conditions are the same as offered to other subcontractors providing a similar scope of service and that reimbursement is not less than the level and amount of payment that Contractor makes for the same scope of services furnished by a provider that is not a FQHC or RHC. Contractor is not required to pay FQHCs and RHCs the Medi-Cal per visit rate for that facility. At its discretion, DHCS reserves the right to review and audit Contractor's FQHC and RHC reimbursement to ensure compliance with State and Federal law and shall approve all FQHC and RHC Subcontracts consistent with the provisions of Welfare and Institutions Code, Section 14087.325(h).

To the extent that Indian Health Programs qualify as FQHCs or RHCs, the above reimbursement requirements shall apply to Subcontracts with Indian Health Programs.

C. Indian Health Programs

Contractor shall reimburse Indian Health Programs for services provided to Members who are qualified to receive services from an Indian Health Program as set forth in 42 USC Section 1396u-2(h)(2), Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009, and, insofar as they do not conflict with Federal law or

regulations, the reimbursement options set forth in Title 22 CCR Section 55140(a).

~~5~~6. Sexually Transmitted Disease (STD)

Contractor shall reimburse ~~l~~**L**ocal ~~h~~**H**ealth ~~d~~**D**epartments **(LDHs)** and non-contracting family planning providers at no less than the appropriate Medi-Cal **Fee For Service (**FFS**)** rate, for the diagnosis and treatment of a STD episode, as defined in ~~MMCD~~ **Medi-Cal Managed Care** Policy Letter No. 96-09. Contractor shall provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to Contractor along with billing information.

~~6~~7. HIV Testing and Counseling

Contractor shall reimburse ~~local health departments~~ **LHDs** and non-contracting family planning providers at no less than the Medi-Cal FFS rate for HIV testing and counseling. Contractor shall provide reimbursement only if ~~local health departments~~ **LHDs** and non-contracting family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to Contractor.

~~7~~8. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization

A. Emergency Services: Contractor is responsible for coverage and payment of emergency services and post stabilization care services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the plan. Contractor may not deny payment for treatment obtained when an enrollee had an ~~e~~**E**mergency ~~m~~**M**edical ~~c~~**C**ondition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114 (a) of the definition of ~~e~~**E**mergency ~~m~~**M**edical ~~c~~**C**ondition. Further, Contractor may not deny payment for treatment obtained when a representative of Contractor instructs the enrollee to seek ~~e~~**E**mergency ~~s~~**S**ervices.

B. Contractor may not limit what constitutes an ~~e~~**E**mergency ~~m~~**M**edical ~~c~~**C**ondition on the basis of lists of diagnoses or symptoms or refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollees ~~p~~**P**rimary ~~c~~**C**are ~~p~~**P**rovider **(PCP)**, the plan, or DHCS of the enrollee's screening and treatment within **ten** ~~10~~ calendar days of presentation for emergency

services. A Member who has an ~~e~~**E**mergency ~~m~~**M**edical ~~c~~**C**ondition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or **to** stabilize the patient.

C. Contractor shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor, or the Member is stabilized sufficiently to permit discharge. The attending emergency ~~p~~**P**hysician, or the provider treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on the Contractor. Emergency Services shall not be subject to Prior Authorization by Contractor.

D. At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management Physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

E. For all non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan Emergency Services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with provision 3~~. Claims Processing,~~ above, and **Title** 42 U**.**S**.**C**.** Section 1396u-2(b)(2)(D).

~~F. Contractor shall not refuse to cover reimbursement for Emergency Services rendered by a non-contracting provider based on the emergency room provider, hospital, or fiscal agent not notifying the Member's Primary Care Physician or Contractor of the Member's screening and treatment within ten (10) calendar days of presentation for emergency. Contractor shall not limit what constitutes an Emergency Medical Condition solely on the basis of lists of diagnoses or symptoms.~~

~~G~~**F.** In accordance with Title 28, CCR, ~~S~~**s**ection 1300.71.4, Contractor shall approve or disapprove a request for post-stabilization inpatient services made by a non-contracting provider on behalf of a Member within 30 minutes of the request. If Contractor fails to approve or disapprove authorization within the required timeframe, the authorization will be

deemed approved. Contractor is financially responsible for post-stabilization service payment as provided in sub-provision C above.

~~H~~**G.** Disputed Emergency Services claims may be submitted to DHCS, Office of Administrative Hearings and Appeals, 1029 J Street, Suite 200, Sacramento, California, 95814 for resolution under the provisions of ~~W&I~~ **Welfare and Institutions** Code ~~S~~**s**ection 14454 and Title 22, CCR, ~~S~~**s**ection 53620 et. seq., except Section 53698. Contractor agrees to abide by the findings of DHCS in such cases, to promptly reimburse the non-contracting provider within 30 calendar days of the effective date of a decision that Contractor is liable for payment of a claim and to provide proof of reimbursement in such form as the DHCS Director may require. Failure to reimburse the non-contracting provider and provide proof of reimbursement to DHCS within 30 calendar days shall result in liability offsets in accordance with ~~W&I~~ **Welfare and Institutions** Code ~~S~~**s**ections 14454(c) and 14115.5, and Title 22, CCR, Section 53702.

~~I~~**H.** Post Stabilization Services: **Post-stabilization care means services provided subsequent to an emergency that a treating physician views as medically necessary after an Emergency Medical Condition has been stabilized. They are not emergency services, which Contractor is obligated to cover. Rather, they are non-emergency services that Contractor should approve before they are provided outside of PACE plan. Contractor must establish and maintain a written plan which provides for coverage of urgently needed out-of-network and post-stabilization care services when either of the following conditions is met:**

1) the services are preapproved by the PACE organization; or

2) the services are not preapproved by the PACE organization because the PACE organization did not respond to a request for approval within one hour after being contacted or cannot be contacted for approval.

Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR, ~~Section~~ 422.113(c). Contractor is financially responsible for post-stabilization services obtained within or outside Contractor's network that are pre-approved by a plan provider or other entity representative. Contractor is financially responsible for post-stabilization care services obtained within or outside Contractor's network that are not pre-approved by a plan provider or other Contractor representative, but administered to maintain the enrollee's stabilized

condition within **one** ~~1~~ hour of a request to Contractor for pre-approval of further post-stabilization care services.

~~J.~~**I.** Contractor is also financially responsible for post-stabilization care services obtained within or outside Contractor's network that are not pre-approved by a plan provider or other entity representative, but administered to maintain, improve or resolve the enrollee's stabilized condition if Contractor does not respond to a request for pre-approval within 30 minutes; Contractor cannot be contacted; or Contractor's representative and the treating ~~p~~**P**hysician cannot reach an agreement concerning the enrollee's care and a plan ~~p~~**P**hysician is not available for consultation. In this situation, Contractor must give the treating ~~p~~**P**hysician ~~the~~ **an** opportunity to consult with a plan ~~p~~**P**hysician and the treating ~~p~~**P**hysician may continue with care of the patient until a plan ~~p~~**P**hysician is reached or one of the criteria of 42 CRF, ~~Section~~ 422.~~133~~ **113**(c)(3) is met.

~~K.~~**J.** Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when a plan ~~p~~**P**hysician with privileges at the treating hospital assumes responsibility for the Member's care, a plan ~~p~~**P**hysician assumes responsibility for the Member's care through transfer, a plan representative and the treating ~~p~~**P**hysician reach an agreement concerning the enrollee's care~~:~~**,** or the enrollee is discharged.

~~L.~~**K.** Consistent with 42 CFR, ~~S~~**s**ections 438.114(e), 422.113(c)(2), and 422.214**,** Contractor is financially responsible for payment for post-stabilization services following an emergency admission at the hospital's Medicare rate if the member is Medicare eligible or at the hospital's Medi-Cal FFS payment amounts if the member is eligible for Medi-Cal only for general acute care inpatient services rendered by a non-contracting hospital, unless a lower rate is agreed to in ~~a~~ writing **and** signed by the hospital.

1) For the purposes of this Paragraph L, the Medi-Cal payment amount for dates of service when the post-stabilization services were rendered shall be in the Medi-Cal payment amounts that are:

a) Published in the annual All Plan Letter issued by the Department in accordance with California Welfare and Institutions Code section 14091.3, which for the purposes of this Paragraph L ~~This provision~~ shall apply to all ~~general~~ acute care hospitals, including hospitals contracting with the State under the Medi-Cal Selective

Exhibit A, Attachment 8
Provider Compensation Arrangements

Provider Contracting Program (**Welf. & Inst. Code**, ~~W & I Section~~ § 14081 et seq.), less any associated direct or indirect medical education payments to the extent applicable**, which Item (a) shall be applicable until it is replaced by the implementation of the payment methodology in Item (b) below.**

b) Established in Welfare and Institutions Code section 14105.28, upon the Department's implementation of the payment methodology based on diagnosis-related groups, which for the purposes of this Paragraph K shall apply to all acute care hospitals, including public hospitals that are reimbursed under the Certified Public Expenditure (CPE) Basis methodology (Welf. and Inst. Code § 14166. et. seq.), less any associated direct or indirect medical education payments to the extent applicable

2) Payment made by Contractor to a hospital that accurately reflects the payment amounts required by this provision shall constitute payment in full **under this Paragraph L,** and ~~the payment~~ shall not be subject to subsequent adjustments or reconciliations by Contractor, except as provided by Medicaid and Medi-Cal law and regulations. A hospital's tentative and final cost settlement processes required by **California Code of Regulations section** 51536 shall not have any effect on payments made by Contractor pursuant to this ~~Subprovision~~ **paragraph** L.

Exhibit A, Attachment 9
Access and Availability

1. General Requirement

A. **Contractor shall establish and implement a written plan to furnish care that meets the needs of each member in all care settings 24 hours a day, every day of the year. Contractor shall furnish comprehensive medical, health, and social services that integrate acute and long-term care.**

B. **The PACE benefit package for all members includes the following:**

1) all Medicare-covered items and services;

2) all Medicaid-covered items and services, as specified in the State's approved Medicaid plan; and

3) other services determined necessary by the interdisciplinary team to improve and maintain the member's overall health status.

C. **While enrolled in the Contractor's PACE plan, the member must receive Medi-Cal benefits solely through Contractor's PACE organization. Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles copayments, coinsurance, or other cost-sharing do not apply.**

D. **Contractor must operate at least one PACE center either in, or contiguous to, its defined service area with sufficient capacity to allow routine attendance by members. The PACE Center must comply with the physical environment requirements of 42 CFR 460.72.**

E. **Contractor must ensure accessible and adequate services to meet the needs of its members. If necessary, Contractor must increase the number of PACE centers, staff, or other PACE services.**

F. **If Contractor operates more than one center, each PACE center must offer the full range of services and have sufficient staff to meet the needs of members.**

G. **At a minimum, the following services must be furnished at each PACE center:**

Exhibit A, Attachment 9
Access and Availability

a. Primary care, including physician and nursing services;

b. Social services;

c. Restorative therapies, including physical therapy and; occupational therapy;

d. Personal care and supportive services;

e. Nutritional counseling;

f. Recreational therapy; and

g. Meals.

~~A.~~**H.** Contractor shall ensure that each Member has a ~~Primary Care Provider~~**(PCP~~)~~** who is available ~~and physically present at the~~ ~~Service Site~~ for sufficient time to ensure access for the assigned Member upon request by the Member or when medically required and to ensure **c**ase **m**anagement of the Member on an on-going basis. This requirement does not preclude an appropriately licensed professional from being a substitute for the ~~Primary Care Provider~~ **PCP** in the event of vacation, illness or other unforeseen circumstances.

~~B.~~**I.** Contractor shall ensure Members access to all Medically Necessary specialists through staffing, subcontracting, or referral. Contractor shall ensure adequate staff within the Service Area, including Physicians, administrative and other support staff directly and/or through Subcontracts, sufficient to assure that health services shall be provided.

J. Contractor shall ensure that telehealth is recognized as a legitimate means by which a member may receive health care services from a health care provider without in-person contact with the health care provider, pursuant to the provisions of Welfare and Institutions Code section 14594.

a. Contractor shall not require that in-person contact occur between a health care provider and a patient before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and Contractor, and between Contractor and its participating providers or provider groups.

b. **Contractor shall not limit the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the PACE organization, and between the PACE organization and its participating providers or provider groups.**

c. **Contractor may not require the use of telehealth when the health care provider has determined that it is not appropriate**.

2. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor providers' compliance with these requirements.

A. Appointments

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, **routine specialty referral appointments,** emergency care, adult ~~i~~**I**nitial ~~h~~**H**ealth ~~a~~**A**ssessments **(IHAs),** and procedures for obtaining appointments with specialists. For purposes of this provision, "Urgent Care" means "on-site" Urgent Care**. Contractor shall also include procedures for follow-up on missed appointments.**

B. Urgent Care

Contractor shall ensure that a Member needing Urgent Care shall be seen within 24 hours upon request. For purposes of this provision, "Urgent Care" means "on-site" Urgent Care.

C. Waiting Times

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and

return), and ~~in obtaining various types of appointments~~ **time to obtain various types of appointments indicated in Paragraph A**.

D. Telephone Procedures

Contractor shall **require providers to** maintain a procedure for triaging Members' telephone calls, providing telephone medical advice **(if it is made available)**, and accessing telephone interpreters.

E. After Hours Calls

At a minimum, Contractor shall ensure that a Physician or ~~Registered Nurse~~ **an appropriate licensed professional** under his **or** ~~(~~her~~)~~ supervision shall be available for after-hours calls.

F. Sensitive Services

Contractor shall implement and maintain procedures to ensure confidential access in a timely manner to Sensitive Services without Prior Authorization for all Members.

1) Sexually Transmitted Diseases (STDs)

Contractor shall provide access to STD services without Prior Authorization to all Members both within and outside its provider network. Members may access out-of-plan STD services through ~~local health department (~~LHD~~)~~ clinics, family planning clinics or through other community STD service providers. Members may access LHD clinics and family planning clinics for diagnosis and treatment of a STD episode.

2) HIV Testing and Counseling

a. Members may access confidential HIV counseling and testing services through the Contractor's provider network and through out-of-network local LHD and family planning providers.

b. Contractor shall develop, implement and maintain policies and procedures for the treatment of HIV infection and AIDS. Contractor shall submit any changes in these policies and procedures to DHCS at least 30 days prior to their implementation.

Exhibit A, Attachment 9
Access and Availability

G. Access for Disabled Members

Contractor's facilities shall comply with the requirements of Title III~~I~~ of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

H. Unusual ~~or Seldom Used~~ Specialty Services

Contractor shall arrange for the provision of Unusual ~~or Seldom Used~~ Specialty Services from specialists outside the network **if unavailable within Contractor's network,** when **it is** determined ~~M~~**m**edically ~~N~~**n**ecessary.

3. Emergency Care

~~Contractor shall ensure that a Member with an Emergency Medical Condition as defined in Exhibit E, Attachment 1, Definitions, shall be seen immediately and Emergency Services will be available and accessible within the Service Area 24 hours a day. Contractor shall ensure adequate follow-up care for those Members who require non-emergency care and who are denied services in the emergency room.~~

Contractor shall establish and maintain a written plan to handle emergency care as required by 42 CFR 460.100. The plan must ensure that CMS, the State, and PACE members are held harmless if Contractor does not pay for emergency services.

Emergency care is appropriate when services are needed immediately because of an injury or sudden illness and the time required to reach Contractor or one of its contract providers, would cause risk of permanent damage to the member's health. Emergency services include inpatient and outpatient services that meet the following requirements:

A. Are furnished by a qualified emergency services provider, other than the Contractor or one of its contract providers, either in or out of the Contractor's service area;

B. Are needed to evaluate or stabilize an emergency medical condition. An emergency medical condition means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of

health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1) Serious jeopardy to the health of the member;

2) Serious impairment to bodily functions;

3) Serious dysfunction of any bodily organ or part.

Contractor must ensure that the member or caregiver, or both, understand when and how to get access to emergency services and that no prior authorization is needed.

Contractor must provide for the following:

1) An on-call provider, available 24–hours per day to address member questions about emergency services and respond to requests for authorization of urgently needed out-of-network services and post stabilization care services following emergency services.

2) Coverage of urgently needed out-of-network and post-stabilization care services when either of the following conditions are met:

a. The services are preapproved by Contractor; and

b. The services are not preapproved by Contractor because Contractor did not respond to a request for approval within 1 hour after being contacted or cannot be contacted for approval.

~~A~~**C**. Contractor shall cover Emergency **Medical** Services without Prior Authorization **pursuant to California Code of Regulations title 28 section 1300.67(g), and ~~s~~ection 53216**. **Contractor shall coordinate access to emergency care services in accordance with the Contractor's DHCS-approved emergency department protocol (see Exhibit A, Attachment 7)**.

~~B~~**D**. Contractor shall ensure adequate follow-up care for those Members who have been screened in the Emergency Room and require non-emergency care.

Exhibit A, Attachment 9
Access and Availability

~~C~~**E**. Contractor shall ensure that a plan or contracting Physician is available 24 hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary.

4. Changes in ~~Availability or~~ Location of ~~Covered Services~~ PACE Center

~~Contractor shall obtain DHCS approval prior to making any substantial change in the availability or location of services to be provided under this Contract except in the case of unforeseen circumstances. A proposal to change the location of services or to reduce their availability shall be given to the DHCS at least 30 days prior to the proposed effective date.~~

Contractor shall provide notification to DHCS at least 180 calendar days prior to making any substantial change in the location of PACE Center. In the event of an emergency or other unforeseeable circumstances, Contractor shall provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible.

5. ~~Civil Rights Act of 1964~~ Nondiscrimination and Language Access

A. Contractor shall ensure compliance with Section 1557 of the Affordable Care Act of 2010 and any implementing regulations (42 U.S. Code § 18116; 45 C.F.R. Section 92) that prohibit any entity operating a health program or activity, any part of which receives federal financial assistance, from discriminating against persons based on sex, race, color, national origin, age or disability. Contractor shall comply with All Plan Letter (APL) 17-011, Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act (June 30, 2017), including any superseding All Plan Letter. Contractor shall use an up-to-date template Notice of Non-Discrimination to be provided by DHCS and shall ensure that its Notice of Non-Discrimination contains contact information for the DHCS Office of Civil Rights and instructions for filing a discrimination complaint directly with the DHCS Office of Civil Rights.

~~A~~**B**. Contractor shall ensure compliance with Title ~~6~~ **VI** of the Civil Rights Act of 1964 **and any implementing regulations** (42 U.S.C. ~~Section~~ 2000d, 45 C.F.R. ~~Part~~ **section** 80) ~~which prohibits recipients of federal financial assistance from discriminating against persons based on race, color, or national origin~~. **Contractor shall ensure equal access to health care services for limited English proficient Medi-Cal Members or potential**

members through provision of high quality interpreter and linguistic services.

~~B. Contractor shall provide 24-hour access to interpreter services for limited English proficient Medi-Cal Members to health care services within Contractor's network either through telephone language services or interpreters.~~

C. Contractor shall ensure compliance with California nondiscrimination laws, including Section 14029.91 of the Welfare and Institutions Code and Section 11135 of the Government Code.

6. Cultural and Linguistics Program

Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall be accountable for the quality of health care delivered, whether preventive, primary, specialty, emergency or ancillary care services regardless of the number of contracting or subcontracting layers between Contractor and the individual practitioner delivering care to the Member.

A. Linguistic Capability of Employees

Contractor shall assess, identify, and report the linguistic capability of interpreters or bilingual employees and contracted staff (clinical and non-clinical).

B. Group Needs Assessment

1) Contractor shall ensure that a group needs assessment of Members is completed. This group needs assessment shall be conducted in conjunction with the health education group needs assessment, and shall include identification of linguistic needs of the groups that speak a primary language other than English and of all cultural groups within the Service Area.

2) The findings of the assessment shall be maintained as a program description entitled "Cultural and Linguistic Services Program". In the program description, Contractor shall summarize the methodology and findings of the group needs assessment of the linguistic needs of non-English speaking groups, as well as the cultural needs of all plan Members, and outline the proposed services to be implemented to address the timeline for

implementation with milestones, and the responsible individual. Contractor shall also identify the individual with overall responsibility for the activities to be conducted under the plan.

3) The results of the group needs assessment shall be considered in the development of any Marketing materials prepared by Contractor.

C. Program Implementation and Evaluation

Contractor shall develop and implement policies and procedures for assessing the performance of individuals who provide linguistic services as well as for overall monitoring and evaluation of the Cultural and Linguistic Service Program.

7. Linguistic Services

A. ~~Contractor shall provide linguistic services to Members and potential Members residing in Contractor's Service Area who indicate their primary language as other than English.~~
Contractor shall ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries and potential Members receive 24-hour oral interpreter services at all key points of contact, as defined in paragraph D. of this provision, either through interpreters, telephone language services, or any electronic options Contractor chooses to utilize. Contractor shall ensure that lack of interpreter services does not impede or delay timely access to care.

B. Contractor **shall comply with 42 CFR 438.10(d)(4) and** provide**, at a minimum,** the following **linguistic** services **at no cost to Medi-Cal** ~~to those~~ Members ~~at these key points of contact~~ **or potential members**:

~~1) Key Points of Contact~~

~~a. Medical: Advice and Urgent Care telephone, face to face outpatient encounters with health care providers, including pharmacists.~~

~~b. Non-medical: Membership services, orientations, and when scheduling appointments.~~

Exhibit A, Attachment 9
Access and Availability

1) Oral Interpreters, signers, or bilingual providers and provider staff at all key points of contact. These services shall be provided in all languages spoken by Medi-Cal beneficiaries and not limited to those who speak the threshold or concentration- standards languages.

~~2) Types of Services~~

~~a. Interpreters, signers or bilingual providers and provider staff at all Services Sites. These services shall be provided in all languages spoken by Members and not limited to those that speak the threshold concentration standard languages.~~

~~b. Translated written informing materials, including but not limited to the Member Enrollment Agreement Terms and Conditions, enrollee information, welcome packets, and Marketing information.~~

2) Fully translated written informational materials, including but not limited to the Member Services Guide, enrollee information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP Members who speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within the Contractor's Service Area, and by the Contractor in its group needs assessment.

3)~~c~~. Referrals to culturally and linguistically appropriate community service programs.

4)~~d~~. ~~Telecommunications Device for the Deaf (TDD).~~

~~TDDs are electronic devices for text communication via a telephone line used when one or more of the parties have hearing or speech difficulties. TDDs are also known as TTY, which are telephone typewriters or teletypewriters, or teletypes in general.~~

Auxiliary Aids and Services such as California Relay, Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) and American Sign Language.

Exhibit A, Attachment 9
Access and Availability

C. Contractor shall provide translated materials to the following population groups within its Service Area as determined by DHCS:

1) A population group of Medi-Cal beneficiaries residing in the Service Area who indicate their primary language as other than English, and who meet a numeric threshold of 3,000 or five percent (5%) of the Medi-Cal population, whichever is lower.

2) A population group of Medi-Cal beneficiaries residing in the Service Area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single zip code or 1,500 in two continuous zip codes.

D. Key points of contact include:

1) medical care settings: telephone, advice, and urgent care transactions, and outpatient encounters with health care providers including pharmacists; and

2) non-medical care setting: Member services, orientations, and appointment scheduling.

8. Participant Advisory Committee

Contractor shall establish a participant advisory committee in accordance with 42 CFR, Section 460.62. Contractor shall ensure that the committee responsibilities include advisement on educational and operational issues affecting groups who may or may not speak a primary language other than English and cultural competency.

~~**9. Healthcare Surge Events**~~

~~Contractor shall develop and implement policies and procedures to mitigate the effects of natural, manmade, or war-caused disasters involving emergency situations and/or broad healthcare surge events greatly impacting Contractor's health care delivery system. Contractor's policies and procedures shall ensure that Contractor will pro-actively cope with emergency situations and/or healthcare surge events resulting from such disasters or states of emergency, and shall include but are not limited to protecting enrollees, if necessary, by keeping Covered Services available to Members; keeping the revenue stream flowing to Providers In order to keep Covered Services available; transferring Members~~

~~from Provider-to-Provider in the event of diminished plan capacity to keep Covered Services available; and promptly notifying DHCS of the status of the availability and locations of Covered Services, and/or Providers.~~

9. Out-of-Network Providers

If Contractor's network is unable to provide necessary services covered under the Contract to a particular Member, Contractor must adequately and timely cover these services out of network for the Member, for as long as the entity is unable to provide them. Out-of-network providers must coordinate with the entity with respect to payment.

Exhibit A, Attachment 10
Scope of Services

1. Covered Services

A. Contractor shall provide or arrange ~~and pay~~ for~~,~~ **all Medically Necessary** Covered Services ~~to any and all~~ **for** Members**. Covered services are those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of this Contract** ~~needing such services. Contractor shall ensure that the Covered Services and other services required in this Contract are provided to a Member in an amount no less than what is offered to beneficiaries under FFS~~.

B. **Medi-Cal benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost-sharing do not apply.**

C. Contractor may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

2. Medically Necessary Services

Contractor shall provide or arrange for all Medically Necessary Covered Services for Members as stated in Exhibit E, Attachment 1, ~~Definitions~~, provision 26A. Contractor shall ensure that the Medical Necessity of Covered Services is determined through utilization control procedures established in accordance with Exhibit A, Attachment 5, ~~Utilization Management,~~ provisions 1 and 3, unless specific utilization control requirements are included as terms of the Contract under sections applicable to specific services. However, no utilization control procedure or any other policy or procedure used by Contractor shall limit services Contractor is required to provide under this Contract.

For purposes of this Contract, the term "Medically Necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. (Cal. Code Regs., title 22, 51303, subd.(a).)

3. Initial Health Assessments

Exhibit A, Attachment 10
Scope of Services

Contractor shall conduct an initial comprehensive assessment by the IDT on each Member**, periodic reassessments, and unscheduled reassessments** as required by 42 CFR, ~~Section~~ 460.104. This assessment shall include a complete history and physical examination, and **a** health education behavioral assessment. **The IDT must promptly develop a comprehensive plan of care for each member, implement the plan of care, and evaluate the plan of care in compliance with 42 CFR 460.106.**

4. Services for Members

A. Contractor shall ensure that the performance of the initial complete history and physical exam for Members includes, but is not limited to:

1) ~~B~~**b**lood pressure**:** persons who are normotensive shall have blood pressure measurements at least annually~~.~~**;**

2) height and weight;

~~2~~**3**) ~~C~~**c**holesterol**;** total cholesterol shall be measured at least once every ~~5~~ **five** years~~.~~**;**

~~3~~**4**) ~~C~~**c**linical breast examination**;** ~~- w~~**W**omen shall have annual clinical breast examination**s.;**

~~4~~**5**) ~~M~~**m**ammogram**;** all women ~~over age 50~~ shall have a screening mammogram every ~~1~~ **one** to ~~2~~ **two** years, concluding at age 75 unless pathology has been demonstrated;~~.~~

~~5~~**6**) ~~P~~**p**ap ~~S~~**s**mear**;** ~~- beginning at the age of first sexual intercourse~~, ~~p~~**P**ap smears shall be performed every one to three years, depending on the presence or absence of risk factors. Regular screening may be discontinued after age 65 in those ~~participants~~ **members** who have had regular screening with consistently normal results**; and**~~.~~

~~6~~**7**) ~~T~~**t**uberculosis (TB) screening**:** ~~-~~ all Members shall receive testing upon enrollment and annual screening**s** shall be performed as a part of the history and physical~~.~~**, including a Mantoux skin test on all persons determined to be high risk.**

Exhibit A, Attachment 10
Scope of Services

B. Member Preventive Services

Contractor shall cover and ensure the delivery of all preventive services and Medically Necessary diagnostic and treatment services for Members.

1) Contractor shall implement and maintain The Guide to Clinical Preventive Services, a report of the U.S. Preventive Service Task Force (USPSTF) as the minimum acceptable standard for Member Preventive Health Services. The preceding are a core set of preventive services that shall be provided to all asymptomatic, healthy Members, age 21 and older. (This is not an inclusive list of all appropriate preventive services. The presence of risk factors in individual patients shall affect the type and quantity of preventive services that may be appropriate. A given patient may need additional services or core services at more frequent intervals).

2) Contractor shall provide managed health and other diagnostic and treatment services utilizing the IDT approach to assess and evaluate Member needs, initiate and coordinate required care and otherwise provide effective Case Management for each Member. Contractor shall accept responsibility for management of all health care costs and services for each Member, except for those services which are specifically excluded as stated Exhibit E, Attachment 1, provision 26B.

C. Immunizations

1) Contractor is responsible for assuring that all Members are fully immunized. Contractor shall cover and ensure the timely provision of vaccines in accordance with the most current California Adult Immunization recommendations.

2) Contractor shall cover and ensure the provision of age and risk appropriate immunizations in accordance with the findings of the IHA, other preventive screenings and/or the presence of risk factors identified in the health education behavioral assessment.

~~1~~**3**) Appropriate documentation shall be entered in the Member's Medical Record that indicates all attempts to provide immunization(s), instructions as to how to obtain necessary immunizations, or proof of prior immunizations or proof of voluntary refusal of vaccines in the form of a signed statement by the

Member. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record.

~~2) In addition, Contractor shall cover and ensure the provision of age and risk appropriate immunizations in accordance with the findings of the Initial Health Assessment (IHA), other preventive screenings and/or the presence of risk factors identified in the health education behavioral assessment and subsequent periodic health assessments.~~

5. Services for All Members

A. Health Education

1) Contractor shall implement and maintain a **health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Members** ~~system for providing Member health education services, clinical preventive services, health education and promotion and patient education and counseling. The system shall utilize one to one and group interventions, written and audio-visual materials. Contractor shall ensure that the services are provided directly by Contractor or through Subcontracts or formal agreements with other providers specializing in health education services~~.

2) Contractor shall maintain administrative oversight of the ~~program~~ **health education system through a combination of services equivalent to the services of a** ~~by a designated~~ **qualified full-time** health educator.

3) Contractor shall **provide health education programs and services at no charge to Members directly and/or through Subcontracts or other formal agreements with providers that have expertise in delivering health education services to the Member population** ~~arrange for the timely referral and coordination of those services to which Contractor or subcontractor has religious or ethical objections to perform or otherwise support and shall demonstrate ability to arrange, coordinate, and ensure provision of services through referrals at no additional expense to DHCS~~.

Exhibit A, Attachment 10
Scope of Services

4) Contractor shall ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for Members and effective in achieving behavioral change for improved health.

5) Contractor shall ensure that health education materials are written at the sixth grade **reading** level and are culturally and linguistically appropriate for the intended audience.

6) Contractor shall maintain a health education system that ~~includes, at a minimum, the following services~~ **provides education interventions addressing the following health categories and topics**:

a. risk-reduction and healthy lifestyles; tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV; nutrition, weight control, and physical activity; and

b. self-care and management of health conditions: asthma, diabetes; and hypertension.

~~a. Member Education~~

~~(1) Use of Clinical Preventive Services~~

~~(2) Promote Appropriate Use of Plan Services~~

~~b. Clinical Preventive Services, Education, and Counseling~~

~~(1) Nutrition~~

~~(2) Tobacco Prevention and Cessation~~

~~(3) HIV/STD Prevention~~

~~(4) Exercise~~

~~(5) Dental~~

~~(6) Skin Care~~

~~(7) Hygiene~~

~~(8) Injury Prevention~~

~~(9) Immunizations~~

~~(10) Vision~~

~~(11) Hearing~~

~~c. Patient Education and Clinical Counseling~~

~~Diabetes~~

~~(2) Asthma~~

~~(3) Hypertension~~

~~(4) Substance Abuse~~

~~(5) Tuberculosis~~

~~(6) Inpatient - Condition Specific~~

~~(7) Other Outpatient~~

7) Contractor shall develop, implement, and maintain standards, policies and procedures**,** and ensure provision of the following:

a. Member orientation, education regarding health promotion, personal health behavior, and patient education and counseling~~.~~**:**

b. Provider education on health education services~~.~~**; and**

c. Individual health education behavioral assessment, referral, and follow-up.

8) Contractor shall maintain health education policies and procedures, and standards and guidelines**,**~~;~~ conduct appropriate levels of program evaluation**,**~~;~~ and monitor performance by IDT members providing health education services to ensure effectiveness.

9) Contractor shall periodically review the health education system to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates effective implementation of the health education requirements.

10) Contractor shall ensure that individual age appropriate health education behavioral assessments are conducted on all Members within ~~90~~ **60 calendar** days of Enrollment to identify high-risk behaviors of individual plan Members, to assist providers in prioritizing individual health education needs of their assigned patients related to lifestyle, behavior, environment, and cultural linguistic background and to assist providers in initiating and documenting focused health education interventions, referrals and follow-up. ~~Refer to MMCD Policy Letter 99-07 for details.~~ Contractor may modify the tool to fit its population.

~~11) Contractor shall maintain a system for informing Members about health education contributions they can make toward the maintenance of their own medical and dental health.~~

~~12) Contractor shall ensure coordination and integration of the health education system with the Quality Improvement program.~~

~~13) Contractor shall conduct a group needs assessment of its Members to determine health education needs, including literacy level. If not previously submitted, Contractor shall submit to DHCS a report summarizing the methodology, findings, proposed services, key activities, timeline for implementation, and the responsible individuals.~~

11) Contractor shall cover and ensure provision of Comprehensive Case Management including coordination of care services as described in Exhibit A, Attachment 11.

B. Nursing Facility Services

1) Contractor shall ensure that Members, other than Members requesting hospice services, in need of nursing facility services are placed in Facilities providing the appropriate level of care commensurate with the Member's medical needs. These facilities include Skilled Nursing Facilities and Intermediate Care Facilities.

2) Contractor shall base decisions on the appropriate level of care on the determination of whether the Member can live in a community setting without jeopardizing his or her health or safety and not inconsistent with the definitions set forth in **California Code of Regulations** ~~T~~title 22, ~~CCR~~, ~~S~~sections 51118, 51120, 51120.5, 51121, and 51124.5, and the criteria for admission set forth in ~~T~~title ~~22, CCR~~, ~~S~~sections 51335 and 51334.

3) 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.

C. Vision Care**:** ~~-~~Lenses

Contractor shall ensure a vision care services system, consistent with good professional practice, which provides that a Member may be seen initially by ~~either~~ **any** of the following:

1) An optometrist or an ophthalmologist.

2) A PCP before referral to an optometrist or an ophthalmologist.

D. Mental Health Services

1) Contractor shall implement and maintain a mental health services system consistent with good professional practice, which provides that a Member may be seen initially by either of the following:

a. Psychiatrist or psychologist, or a psychiatric social worker who is working under qualified supervision**; or** ~~.~~

b. A PCP before referral to a mental health service provider.

2) Contractor shall implement and maintain policies and procedures for mental health services to include inpatient and outpatient services as determined ~~m~~**M**edically ~~n~~**N**ecessary by the PCP.

E. Tuberculosis (TB)

1) TB screening, diagnosis, treatment**,** and follow-up are covered under ~~the~~ **this** Contract. Contractor shall provide TB care and

treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.

2) Contractor shall coordinate with LHDs in the provision of direct observed therapy as required in Exhibit A, Attachment 11, provision 16 and Attachment 12.

F. Pharmaceutical Services and Provision of Prescribed Drugs

1) Contractor shall provide pharmaceutical services and prescribed drugs, either directly or through Subcontracts, in accordance with all laws and regulations regarding the provision of pharmaceutical services and prescription drugs to Medi-Cal beneficiaries, including, but not limited to, Title 22, CCR, Section 53214, ~~and~~ W&I Code, Section 14185**, Title 42, CFR, Sections 460.90, 460.92, 460.3 and 460.84. PACE plans are not subject to the requirements of the California Executive Order N-01-19, transitioning all pharmacy services for Medi-Cal managed care to a fee-for-service benefit, unless as directive making PACE plans subject to Executive Order N-01-19 is issued. If such a directive is issued, then PACE plans must comply with the terms of that directive, the Executive Order, and any implementing authorities.**

~~1~~**2**) As a minimum, such pharmaceutical services and drugs shall be available to Members during ~~Service Site~~ **PACE Center business** hours.

~~2~~**3**) Contractor shall provide a response to a Prior Authorization request from a Contracting provider for a Member's prescription drugs within 24 hours or one business day.

~~3~~**4**) Contractor ,also shall allow a Member to continue use of a single source drug which was part of a prescribed therapy in effect immediately prior to the Member's enrollment even if the drug is not covered by Contractor, until the drug is no longer prescribed by the Contracting provider.

~~4~~**5**) When the course of treatment provided to a Member by a Contracted provider under emergency circumstances requires the use of drugs, at least a 72-hour supply of a covered outpatient drug or a sufficient quantity of such drugs shall be provided to the

Member to last until the Member can reasonably be expected to have a prescription filled.

~~5)~~**6)** Contractor shall develop and implement effective drug utilization reviews and treatment outcomes to optimize the quality of pharmacy services.

7) Contractor's process should also ensure that drug utilization reviews are appropriately conducted and that pharmacy service and drug utilization Encounter Data are provided to DHCS on a monthly basis.

6. Transportation

Transportation services must be provided in compliance with 42 CFR 460.76.

7. Dietary Services

Dietary services are covered as set forth in 42 CFR 460.78

Exhibit A, Attachment 11
Case Management and Coordination of Care

~~**1. Comprehensive Case Management Including Coordination of Care Services**~~

~~A. Contractor shall ensure the provision of Comprehensive Medical Case Management Services to each Member.~~

~~B. Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including, but not limited to, all Medically Necessary services delivered both within and outside Contractor's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the member.~~

~~2~~1. Interdisciplinary Team Case Management

A. Contractor shall provide managed health and other diagnostic and treatment services utilizing the IDT approach to comprehensively assess and evaluate Member needs, initiate and coordinate required care, and otherwise provide effective Case Management for each Member **in compliance with 42 CFR 460.102, 460.104, 460.106, 460.114, 460.92, and 460.98**.

B. Contractor shall accept responsibility for management of all health care costs and services for each Member, except for those services which are specifically excluded as stated in Exhibit E, Attachment 1, provision 26B.

~~3~~2. Nursing Facility Level of Care

Contractor's IDT shall be responsible for assessing Members for meeting skilled or intermediate nursing facility level of care criteria in accordance with **California Code of Regulations,** ~~T~~title 22, ~~CCR,~~ Sections 51334 and 51335. Evaluation and determination of Members prior to Enrollment in Contractor's plan shall be determined solely by DHCS as meeting the level of care requirements.

43. Infection Control

A. Contractor shall implement and maintain an effective plan for the surveillance, prevention, and control of infection **in compliance with 42 CFR 460.74**. Contractor shall ensure that this plan shall include the scope (both patient care and support services), the persons responsible, the policies and procedures and frequency of review (at least every 2 years), the role and responsibilities of each service, the monitoring activities, and approval by the **g**~~G~~overning **b**~~B~~ody.

Exhibit A, Attachment 11
Case Management and Coordination of Care

B. Contractor shall implement and maintain policies for prevention and control of infection transmission in patients and personnel which include:

1) ~~T~~**t**he application of universal precaution procedures~~.~~**;**

2) ~~T~~**t**he availability of adequate infection control devices and supplies in the patient areas~~.~~**;**

3) ~~I~~**i**nfectious or bio-hazardous waste disposal procedures complying with applicable ~~S~~**s**tate and federal regulations~~.~~**;**

4) ~~I~~**i**solation precautions and procedures~~.~~ **;**

5) ~~C~~**c**leaning and sterilization methods, agents, and schedules, including maintenance of autoclave, spore testing, storage of sterile packs, etc.; and

6) ~~T~~**t**raining and continuing education of all personnel.

C. Contractor shall implement and maintain a procedure for reporting infectious diseases to public health authorities as required by **s**~~S~~tate law.

D. Contractor shall ensure that its infection control policies are maintained by its ~~s~~**S**ubcontractors.

E. Contractor shall ensure the review of patient infections that present the potential for prevention or intervention to reduce the risk of future occurrence.

~~5~~4. Inpatient Care

Contractor shall implement and maintain procedures to monitor Quality of Care provided in an inpatient setting to its Members. If Contractor delegates the QI functions to hospitals, Contractor shall maintain procedures to monitor the delegated function, including review of services provided by its Physicians within the hospital.

5. Out-of-Plan Case Management and Coordination of Care

Contractor shall implement procedures to identify individuals who may need or who are receiving services from out-of-plan providers and/or

Exhibit A, Attachment 11
Case Management and Coordination of Care

programs in order to ensure coordinated service delivery and efficient and effective joint case management.

6. Dental

Contractor shall ensure a dental care services system, consistent with good professional practice that guarantees Members direct access to dental care as determined by the IDT.

7. Immunization Registry Reporting

Contractor shall ensure that member-specific immunization information is periodically reported to an immunization registry(ies) established in the Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports shall be made following the Member's IHA and all other health care visits which result in an immunization being provided. Reporting shall be in accordance with all applicable State and federal laws.

8. Erectile Dysfunction (ED) Drugs and Other ED Therapies

ED drugs and other ED therapies are excluded from coverage under Medi-Cal unless such drug is used to treat a condition other than sexual or erectile dysfunction, and as approved by the Food and Drug Administration. ED drugs and other ED therapies are covered under this contract if they are determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status, as provided under 42 CFR section 460.92(c).

Exhibit A, Attachment 12
Local Health Department Coordination

~~THIS ATTACHMENT INTENTIONALLY LEFT BLANK~~

1. Subcontracts

If the Contractor makes referrals to LHDs for public health services listed in paragraphs A through D below, Contractor shall negotiate in good faith and execute a Subcontract with the LHD in each county that is covered by this Contract in each county zip code service area that is covered by this Contract. The Subcontract shall specify: the scope and responsibilities of both parties in the provision of services to Members; billing and reimbursements; reporting responsibilities; and how services are to be coordinated between the LHD and the Contractor, including exchange of medical information as necessary. The Subcontract shall meet the requirements contained in Exhibit A, Attachment 6, provision 13, regarding Subcontracts.

A. STD services for the disease episode, as specified in Exhibit A, Attachment 8, Provision 10, by DHCS, for each STD, including diagnosis and treatment of the following STDs: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale.

B. HIV Testing and Counseling as specified in Exhibit A, Attachment 8, provision 11.

C. Immunizations as specified in Exhibit A, Attachment 8, provision 12.

D. To the extent that Contractor does not meet this requirement on or before four months after the effective date of this Contract, Contractor shall submit documentation substantiating reasonable efforts to enter into Subcontracts.

2. Local Mental Health Plan Coordination

A. If the Contractor makes referrals to Medi-Cal local mental health plans for specialty mental health services, Contractor shall negotiate in good faith and execute a Subcontract with the MHP in each county zip code service area that is covered by this Contract. The Subcontract shall specify: the scope and responsibilities of both parties in the provision of services to Members; billing and reimbursements; reporting responsibilities; and how services are to be coordinated between the MHP and the Contractor, including

Back to Agenda Back to Item

Exhibit A, Attachment 12
Local Health Department Coordination

exchange of medical information as necessary. The Subcontract shall meet the requirements contained in Exhibit A, Attachment 6, provision 13, regarding Subcontracts. The subcontract shall address:

1) protocols and procedures for referrals between Contractor and the MHP;

2) protocols for the delivery of Specialty Mental Health Services, including the MHP's provision of clinical consultation to Contractor for Members being treated by Contractor for mental illness;

3) protocols for the delivery of mental health services within the PACE IDT scope of practice;

4) protocols and procedures for the exchange of medical records information, including procedures for maintaining the confidentiality of medical records.

5) Procedures for the delivery of Medically Necessary Covered Services to Members who require Specialty Mental Health Services, including:

a) Pharmaceutical services and prescription drugs;

b) Laboratory, radiological and radioisotope services;

c) Emergency room facility charges and professional services;

d) Emergency and non-emergency medical transportation;

e) Home health services; and

f) Medically Necessary Covered Services to Members who are patients in psychiatric inpatient hospitals.

6) Procedures for transfers between inpatient psychiatric services and inpatient medical services to address changes in a Member's medical or mental health condition; and

Exhibit A, Attachment 12
Local Health Department Coordination

7) Procedures to resolve disputes between Contractor and the MHP.

Exhibit A, Attachment 13
Member Services

1. Members Rights and Responsibilities

A. Member Rights and Responsibilities

Contractor shall develop, implement, and maintain **a formal Participant Bill of Rights approved by CMS, in compliance with 42 U.S.C. 1395eee(b)(2)(B), 42 CFR 460.32(a)(5), 460.110, and 460.112, which includes** written policies that address the Member's rights and responsibilities and shall communicate these to its employees, Members, **providers, and, upon request, potential members** ~~and contracted providers~~.

Contractor assures that the rights and protections of the Participant Bill of Rights will be provided, as required by 42 CFR 460.32(a)(5).

Contractor shall have established documented procedures to respond to and rectify a violation of a participant's rights, as required by 42 CFR 460.118.

Contractor must have written policies and implement procedures to ensure that the participant, his or her representative, if any, and staff understand these rights, as required by 42 CFR 460.116.

1) Contractor's written ~~policy regarding Member rights~~ **Participant Bill of Rights** shall include~~, but not be limited to,~~ the following:

a. ~~Member has the right~~ to be treated with ~~dignity and~~ respect, **giving due consideration to the Member's right to** ~~be afforded~~ privacy and **the need to maintain** confidentiality **of the Member's medical information** ~~in all aspects of care, and to be provided humane care from all Contractor's employees and providers at all times and under all circumstances~~.

b. ~~Member has the right~~ not to be discriminated against in the delivery of required services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or source of payment.

~~c. Member has the right to be provided with information about the organization and its services, to be able to choose a Primary Care Physician if another PCP is employed by Contractor, to participate in decision making regarding their~~

~~own health care, including the right to refuse treatment and be informed of the consequences of the decisions, to voice Grievances about the organization or the care received, to formulate advance directives, STD services, and Emergency Services outside Contractor's network pursuant to the federal law, the right to request a State hearing, to have access to their Medical Record, and to disenroll.~~

~~d~~**c.** the Member has the right to be fully informed of his (her) functional status and to request a reassessment by the IDT, to be given reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer (e.g. due to medical reasons or for the Member's welfare or that of other Members).

d. to be provided with information about the organization and its services;

e. to be able to choose a PCP if another PCP is employed by Contractor;

f. to participate in decision making regarding their own health care, including the right to refuse treatment;

g. to voice grievances, either verbally or in writing, about the organization or the care received;

h. to receive oral interpretation services for their language;

i. to formulate advance directives;

j. to have access to sexually transmitted disease services and emergency services outside the Contractor's network pursuant to the federal law;

k. to request a State Medi-Cal Hearing, including information on the circumstances under which an expedited Hearing is possible;

l. to have access to, and where legally appropriate, receive copies of, amend, or correct their Medical Record;

m. to Disenroll upon request;

n. to receive written Member informing materials in alternative formats, including Braille, large size print, and audio format upon request and in accordance with Welfare and Institutions Code section 14182, subdivision (b), criteria (12);

o. to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

p. to receive information about available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;

q. to receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526 (2014); and

r. freedom to exercise these rights without adversely affecting how they are treated by the Contractor, providers, or the State.

2) Contractor's written policy regarding Member responsibilities shall include providing accurate information to the professional staff, following instructions, and cooperating with the providers.

B. Members' Right to Confidentiality

Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of Confidential Information to unauthorized persons inside and outside the network.

2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of Confidential Information, unless such consent is not required pursuant to **California Code of Regulations,** ~~T~~**t**itle 22, ~~CCR~~, ~~S~~**s**ection 51009.

~~3. Contractor shall ensure the Members' confidentiality when accessing Sensitive Services such as STD and HIV testing and counseling.~~

C. Contractor must limit use of restraints as provided in 42 CFR 460.114, as follows:

1) the PACE organization must limit use of restraints to the least restrictive and most effective method available. The term restraint includes either a physical restraint or a chemical restraint.

a. a physical restraint is any manual method or physical or mechanical device, materials, or equipment attached or adjacent to the participant's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

b. a chemical restraint is a medication used to control behavior or to restrict the participant's freedom of movement and is not a standard treatment for the participant's medical or psychiatric condition.

2) If the interdisciplinary team determines that a restraint is needed to ensure the participant's physical safety or the safety of others, the use must meet the following conditions:

a. be imposed for a defined, limited period of time, based upon the assessed needs of the participant.

b. be imposed in accordance with safe and appropriate restraining techniques.

c. be imposed only when other less restrictive measures have been found to be ineffective to protect the participant or others from harm.

d. be removed or ended at the earliest possible time.

3) The condition of the restrained participant must be continually assessed, monitored, and reevaluated.

Exhibit A, Attachment 13
Member Services

~~C.~~**D.** Members' Rights to Advance Directives

Contractor shall implement and maintain written policies and procedures respecting advance directives in accordance with the requirements of 42 CFR, ~~Sections~~ 422.128 ~~(2005)~~ and ~~438.6(i)~~.

2. ~~Member Services~~ PACE Staff

A. Contractor shall maintain the capability to provide Member services to Medi-Cal Members **or potential members** through sufficient assigned and knowledgeable staff.

B. Contractor shall ensure ~~Member services~~ **PACE** staff are trained on all contractually required Member **or potential member** service functions including policies, procedures, and scope of benefits of this Contract. **Contractor shall provide training to maintain and improve the skills and knowledge of each staff member with respect to the individual's specific duties that results in his or her continued ability to demonstrate the skills necessary for the performance of the position, as required by 42 CFR 460.66.**

C. Contractor shall develop a training program for each personal care attendant to establish the individual's competency in furnishing personal care services and specialized skills associated with specific care needs of individual members.

~~C.~~**D.** Contractor shall ensure that ~~Member services~~ **PACE** staff provides necessary support to Members with chronic conditions (such as asthma, diabetes, congestive heart failure) and disabilities, including assisting Members with complaint and grievance resolution, access barriers, and disability issues and referral to appropriate clinical services staff.

E. Each member of Contractor's staff that has direct member contact, (employee or contractor) must meet the following conditions, as required by 42 CFR 460.64:

1) Be legally authorized (for example, currently licensed, registered or certified if applicable) to practice in the State in which he or she performs the function or action;

2) Only act within the scope of his or her authority to practice;

3) **Have 1 year of experience with a frail or elderly population. If the individual has less than 1 year experience but meets all other requirements in this Provision 2.E, then the individual must receive appropriate training from the PACE organization on working with a frail or elderly population upon hiring;**

4) **Meet a standardized set of competencies for the specific position description established by the PACE organization and approved by CMS before working independently;**

5) **Be medically cleared for communicable diseases and have all immunizations up-to-date before engaging in direct member contact.**

F. **Federally-defined qualifications for physician. In addition to the qualification specified in paragraph (D) of this section, a physician must meet the qualifications and conditions in 42 CFR 410.20.**

3. Written Member Information

A. Contractor shall provide to all Members, upon Enrollment in Contractor's plan, the Member Enrollment Agreement/Terms and Conditions and Disclosure Form materials, which constitute a fair disclosure of the provisions of the covered health care services. In the event there are changes in the Member Enrollment Agreement/Terms and Conditions at anytime during the Member's enrollment, Contractor must provide to the Member an updated copy of the information ~~to the Member~~ at least 60 days before any change, and explain the changes to the Member and his or her representative or caregiver in a manner they understand.

B. **To provide Member information in any format other than as printed materials, including but not limited to in electronic format or upon request, Contractor must submit their process to DHCS for review and approval before implementing.**

C. **Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level, or as determined appropriate through the Contractor's group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions.**

Exhibit A, Attachment 13
Member Services

D. **Member information shall include the Member Enrollment Agreement/Terms and Conditions and Disclosure Form materials, significant mailings and notices, and any notices related to Grievances, actions, and Appeals. All Member information shall be in a format that is easily understood and in a font size no smaller than 12-point.**

1) Written Member-information shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 9, provision 10.

2) Written Member information shall be provided in alternative formats (including Braille, large size print, or audio format) and through auxiliary aids and services upon request and in a timely fashion appropriate for the format being requested, and taking into consideration the special needs of Members with disabilities or LEP.

3) Contractor shall establish policies and procedures to enable Members to make a standing request to receive all Member information in a specified threshold language or alternative format.

4) Member information in English shall include taglines and information on how to request auxiliary aids and services, including materials in alternative formats, in large print font and all State threshold languages, as identified by DHCS. The taglines shall explain the availability of written Member information translated in that language or oral interpretation to understand the information provided, and the toll-free and TTY/TDD telephone number for these language assistance services.

~~B~~**E.** Contractor shall provide to all Members a Member Enrollment Agreement/Terms and Conditions upon Enrollment that includes the following information:

1) **The plan** ~~N~~name, address, ~~and~~ **toll-free** telephone number **and service area covered by** ~~of Contractor's~~ ~~health~~ **the PACE** plan.

2) A description of all ~~C~~**c**overed **benefits and all available** ~~S~~**s**ervices provided by Contractor, including health education, interpretive services **provided by plan personnel and at the PACE center**

and an explanation of any service ~~limitations and~~ exclusions from coverage **or charges for services** ~~, and identification of all services that are delivered through contracts~~.

3) An explanation of the eligibility criteria and intake process for Enrollment in Contractor's health plan.

4) ~~Process~~ **Procedures** for ~~obtaining~~ **accessing** Covered Services **including that Covered Services shall be obtained through the plan's providers unless otherwise allowed under this contract** ~~and referral to Contracted Providers, the address and telephone number of each Service Site~~:

~~The hours and days when each of these Facilities is open, the services and benefits available, and the telephone number to call after normal business hours including the TDD number.~~
a description of the Member identification card issued by the Contractor, if applicable, and an explanation as to its use in authorizing or assisting Members to obtain services.

5) Procedures for requesting a change in PCP, if more than one PCP is employed by Contractor, including requirements for a change in PCP, and reasons for which a request may be denied.

6) ~~Information concerning the availability~~ **The purpose** and value of scheduling an ~~initial health assessment~~ **IHA** appointment.

7) A description of the IDT and responsibilities.

8) Explanation of the Member reassessment process by the health plan and for Member requests for reassessment.

9) The appropriate use of health care services.

10) The availability and procedures for obtaining after hours services (24-hour basis) and care, including the appropriate provider locations and telephone numbers. **This shall include an explanation of the Member's right to interpretive services, at no cost, to assist in receiving after hours services.**

11) Definition of what constitutes an emergency medical condition, emergency health care and post-stabilization services, in accordance with 42 CFR § 460.100, and that prior

authorization is not required to receive emergency services. Include the use of 911 for obtaining emergency services.

~~11~~**12**) Procedure for obtaining emergency health care **from specified plan providers or from non-plan providers, including** ~~both within and~~ outside Contractor's Service Area.

13) Process for referral to specialists in sufficient detail so Member can understand how the process works, including timeframes.

~~12~~**14**) Procedures for obtaining any transportation services offered by Contractor, and how to obtain such services.

~~13) The causes for which a Member shall be disenrolled from Contractor as stipulated in Exhibit A, Attachment 16, provision 3. Disenrollments.~~

~~14~~**15**) Procedures for filing a ~~G~~**g**rievance~~s~~ ~~and~~ or ~~A~~**a**ppeal~~s~~ **pursuant to 42 CFR 460.122, either** orally ~~and~~ **or** in writing**, or over the phone,** including procedures for appealing decisions regarding Member's coverage, benefits or relationship to the organization or other dissatisfaction with the Contractor and/or providers. Include the **toll-free telephone number a Member can use to file a grievance or appeal, and the** title, address, and telephone number of the person responsible for processing and resolving ~~G~~**g**rievances and ~~Appeals and person responsible for~~ providing assistance in completing the request. Information regarding the process shall include the **requirements for timeframes to file a grievance or appeal,** and the timelines for the Contractor to acknowledge receipt of ~~G~~**g**rievance**s** ~~and Appeals~~, to resolve ~~G~~**g**rievance~~'~~s ~~and Appeals~~, and to notify the Member of the resolution of ~~G~~**g**rievances ~~and~~ **or** ~~A~~**a**ppeals. Information shall be provided informing the Member that services previously authorized by the Contractor ~~shall~~ **will** continue while the ~~Appeal~~ **grievance** is being resolved.

16) The causes for which a Member shall lose entitlement to receive services under this Contract as stipulated in Exhibit A, Attachment 16, provision 3.

~~15~~**17**) Procedures for Disenrollment, including an explanation of the Member's right to ~~d~~**D**isenroll without cause at any time.

~~16~~**18**) An explanation of specific rights to which a Member is entitled.

~~17~~**19**) A description of the Member's premiums and procedures for payment of premiums, including share of cost.

~~18~~**20**) Explanation of a Member's obligation to inform Contractor of a move or more than a 30-day absence from Contractor's Service Area.

~~19~~**21**) Information on the Member's right to the **Medi-Cal** State ~~h~~**Hearing** process**,** **the method for obtaining a Hearing, the timeframe to request a Hearing, and the rules that govern representation in a Hearing**. **Include information on the circumstances under which an expedited State Hearing is possible and information regarding assistance in completing the request,** regardless ~~of whether or not an Appeal~~ **grievance** has been submitted or if the ~~Appeal~~ **grievance** has been resolved, pursuant to **California Code of Regulations ,** ~~T~~**t**itle 22, ~~CCR,~~ Section 53452, when a health care service requested by the Member or provider has been denied, deferred**,** or modified. **Information on State Hearings shall also include information on the timelines which govern a Member's right to a State Hearing, pursuant to Welfare and Institutions Code Section 10951 and** ~~T~~**t**he State Department of Social Services' Public Inquiry and Response Unit toll**-** free telephone number ~~is~~ (**1**-800~~)~~ 952-5253**) to request a State Hearing. Information shall include that services previously authorized by the Contractor will continue while the State Hearing is being resolved if the Member requests a Hearing in the specified timeframe**.

22) Procedures for providing female Members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a woman's health specialist.

23) Information on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program. Contractor shall include this information with all Member Service Guides sent to Members after the date such information is furnished to Contractor by DHCS.

~~21~~**24**) Information on how to access State resources for investigation and resolution of Member complaints, including **description of** the DHCS Medi-Cal Managed Care Ombudsman **Program and** toll-free telephone number (1-888-452-8609).

~~22~~**25**) A notice regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor. Pursuant to California Health and Safety Code, ~~S~~**s**ection 7158.2, this notice must be provided **upon enrollment and** annually **thereafter** in the evidence of coverage, **(Member Enrollment Agreement/Terms and Conditions**), health plan newsletter**,** or any other direct communications with Members.

~~23~~**26**) A statement as to whether the ~~plan~~ **Contractor** uses provider financial bonuses or other incentives with its contracting providers of health care services and that the Member may request additional information about these bonuses or incentives from the plan, the Member's provider or the provider's group **or independent practice association**, pursuant to California Health and Safety Code, ~~S~~**s**ection 1367.10.

~~24~~**27**) A notice if the plan uses a drug formulary~~,~~**.** **Pursuant to California Health and Safety Code, Section 1363.01, the notice shall: (1) be in the language that is easily understood and in a format that is easy to understand; (2)** includ**e**~~ing~~ an explanation of what a formulary is**,** how the plan decides which prescription drugs are included in or excluded from the formulary, and how often the formulary is updated~~.~~**;** ~~Pursuant to California Health and Safety Code, Section 1363.01, this notice also must~~ **(3)** indicate that the Member can request information regarding whether a specific drug is on the formulary and the telephone number for requesting this information~~.~~; **and (4) indicate that the presence of a drug on the plan's formulary does not guarantee that a Member will be prescribed that drug by his or her prescribing provider for a particular medical condition.**

~~25) A notice if a plan uses binding arbitration to settle disputes, pursuant to California Health and Safety Code, Sections 1363 and 1363.1, and the California Code of Civil Procedures, Section 1295.~~

~~26) A statement that the State of California must seek repayment of Medi-Cal benefits from the estate of a deceased Medi-Cal~~

~~beneficiary for services on or after the beneficiary's 55th birthday. For Medi-Cal beneficiaries enrolled (either voluntarily or mandatorily) in a managed care organization, the State must seek recovery of the total premium/capitation payments for the period of time they were enrolled in the managed care organization. Additionally, any other payments made for services provided by non-managed care provider will also be recovered from the estate.~~

28) Policies and procedures regarding a Members' right to formulate advance directives. This information shall include the Member's right to be informed by the Contractor of state law regarding advance directives, and to receive information from the Contractor regarding any changes to that law. The information shall reflect changes in State law regarding advance directives as soon as possible, but no later than 90 calendar days after the effective date of change.

29) Instructions on how a Member can view online, or request a copy of, Contractor's non-proprietary clinical and administrative policies and procedures; and

30) Any other information determined by DHCS to be essential for the proper receipt of Covered Services.

~~C~~**F**. Contractor shall provide the following information to the Member or Member's family unit either in the form of a cover letter or insert in the above prescribed Member Enrollment Agreement/Terms and Conditions~~.~~**:**

1) each Member's effective date of Enrollment and term of Enrollment~~.~~**; and**

2) the name, telephone number, and ~~Service Site~~ **PACE Center** address of the PCP chosen by or assigned to the Member.

~~D~~**G**. Member Identification Card

Contractor shall issue a Member identification card to each Member ~~upon Enrollment in Contractor's health plan,~~ which identifies the Member and authorizes the provision of Covered Services to the Member. The card shall specify that Emergency Services rendered to the Member by non-contracting providers are reimbursable by **the** Contractor without Prior Authorization by the IDT.

~~E. Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Contractor's group needs assessment and approved by DHCS. The written Member Information shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions.~~

~~Written Member-informing materials shall be translated into the identified threshold and concentration languages discussed In Exhibit A, Attachment 9, provision 7, Linguistic Services.~~

~~Written Member informing materials shall be provided in alternative formats, (including Braille, large size print, and or audio format) upon request and in a timely fashion appropriate for the format being requested.~~

~~Contractor shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.~~

4. Notification ~~to Members About~~ of Changes in Access to Covered Services

A. Contractor shall ~~notify~~ **ensure Medi-Cal** Members **are notified** in writing of any changes in the availability or location of Covered Services ~~being provided by Contractor~~ at least 30 calendar days prior to the effective date of such changes. In the event of an emergency or other unforeseeable circumstance, Contractor shall provide notice of the emergency or unforeseeable circumstance to DHCS as soon as possible. The notification must **also** be **presented to and** approved **in writing** by the Department prior to **its** release ~~and need only be sent to those Members affected by the change~~.

5. Primary Care Physician Selection

A. Contractor shall implement and maintain DHCS' approved **policy and** procedures to ensure that each Member has an appropriate and available PCP upon Enrollment in Contractor's plan.

B. Contractor shall ensure that the Member is assigned to a PCP who is an employee of Contractor's plan or otherwise approved by DHCS and ~~Centers for Medicare and Medicaid Services (~~CMS~~)~~ and is responsible for the medical coordination of the Member's health care consistent with federal and State statutes and regulations. In the event the Member becomes dissatisfied with the PCP, Contractor shall allow the Member to

choose another PCP who is employed by Contractor. Contractor shall employ sufficient number of PCPs at all its ~~Service Sites~~ **PACE Centers** to ensure access to appropriate high-quality health care.

C. Contractor shall provide the Member sufficient information (verbal and written) in the appropriate language and reading level about the PCPs available.

Exhibit A, Attachment 14
Member Grievance and Appeals

1. Member Grievance Procedure

A. Contractor shall establish and maintain a **written** procedure for submitting, documenting, processing, and resolving all **medical and nonmedical** Member Grievances, **as required by 42 CFR 460.32(a)(6) and 460.120** in the timeframes outlined in provision 4~~.~~**,** paragraph C, of this Attachment while maintaining confidentiality of the Member's Grievance. Contractor shall submit the procedure to DHCS for review and approval prior to implementation.

B. Contractor shall designate an officer of the plan~~,~~ **(**e.g., chief executive officer, administrative director**,** or medical director**)** to have primary responsibility for maintenance of the procedures, review of their operations, and utilization of any emergent patterns of Grievances to formulate policy changes and procedural improvements in the administration of the plan.

C. **A grievance is a complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished.**

1) Process to resolve grievances. A PACE organization must have a formal written process to evaluate and resolve medical and nonmedical grievances by members, their family members, or representatives.

2) Notification to members. Upon enrollment, and at least annually thereafter, the PACE organization must give a member written information on the grievance process.

3) Minimum requirements. At a minimum, the PACE organization's grievance process must include written procedures for the following:

a. How a member files a grievance.

b. Documentation of a member's grievance.

c. Response to, and resolution of, grievances in a timely manner.

d. Maintenance of confidentiality of a member's grievance.

Exhibit A, Attachment 14
Member Grievance and Appeals

4) Continuing care during grievance process. The PACE organization must continue to furnish all required services to the member during the grievance process.

5) Explaining the grievance process. The PACE organization must discuss with and provide to the member in writing the specific steps, including timeframes for response, that will be taken to resolve the member's grievance.

6) Analyzing grievance information. The PACE organization must maintain, aggregate, and analyze information on grievance proceedings. This information must be used in the PACE organization's internal quality assessment and performance improvement program.

D. A written summary of Grievances including number, type, location, and disposition shall be reviewed periodically by the governing body of the plan and by an officer of the plan or designee. As a part of this review, the reviewers evaluating the summary will determine an emergent pattern of Grievances to be utilized in the formation of policy changes and procedural components in the plan's administration. The execution of each review shall be documented.

E~~D~~. Contractor shall provide a system for addressing any cultural or linguistic requirements related to the processing of Member Grievances prescribed in the contract between the plan and the department.

2. Grievance Systems Oversight

A. Contractor shall maintain in its files copies of all Grievances, the responses to them, and logs recording them; for a period of five years from the date the Grievance was filed.

B. Contractor shall submit a summary of all Grievances in Contractor's quarterly report. The Grievance summary is due 45 days from the date of the end of the reporting quarter.

C. Contractor shall ensure a procedure for the expedited review and disposition of Grievances in the event of a serious or imminent health threat to a Member, in accordance with Health and Safety Code ~~S~~**s**ection~~s~~ 1368**.01** ~~and 1368.02~~**.**

Exhibit A, Attachment 14
Member Grievance and Appeals

3. Member Grievance Assistance

A. Contractor shall provide at least one telephone number for the filing of complaints that shall ensure that Members calling from within the plan's Service Area ~~shall~~ **will** not have to pay long distance charges. Contractor shall provide written notice to Members of the telephone numbers and procedures for filing Grievances.

~~B. Contractor shall ensure that Members are informed of the Grievance processes in writing and provide to Members upon Enrollment into the plan and at least annually thereafter~~.

~~C~~**B**. A person at ~~each service site~~ **the PACE Center** shall promptly furnish Grievance forms and a copy of the Grievance procedures to Members when requested in person, by telephone**,** or by mail.

~~D~~**C**. A person at ~~each Primary Care Service Site and other locations designated by Contractor~~ **the PACE Center** shall provide assistance in the filing of Grievances.

4. Member Grievance Process

A. Each Grievance received in person or by telephone or in writing in accordance with the established procedure shall be recorded in writing, including the date, time, identification of the Member filing the Grievance, identification of the individual recording the Grievance, description of the Grievance, action taken by the health plan, identification of the individual responsible for resolving Grievances, disposition, and date of notification to the Member. Contractor shall submit all medical quality of care Grievances immediately to the medical director or Chief Medical Officer for action.

B. The management or supervisory staff responsible for the services or operations which are the subject of the Grievance shall promptly review the Grievance.

C. Within five days of receipt of a Grievance, Contractor shall provide to the Member who files a Grievance an acknowledgement of receipt of the Grievance and identification of the person or unit, which may be contacted about the Grievance. Contractor shall notify the Member of the disposition of the Grievance or document reasonable efforts to resolve the Grievance normally within 30 days of the date the Grievance was received. When

Contractor is unable to distinguish between Grievances and inquiries, they shall be processed as Grievances.

D. Any Member whose Grievance is resolved or unresolved shall have the right to request a State ~~h~~**H**earing. Submission of a Grievance shall not be construed as a waiver of the member's right to request a State ~~h~~**H**earing in accordance with **California Code of Regulations,** ~~T~~**t**itle 22, ~~S~~**s**ections 50951, 51014.1, and 51014.2.

E. In the event resolution is not reached within 30 days, the Member shall be notified in writing by Contractor of the status of the Grievance and shall be provided with an estimated completion date of the resolution. Such notice shall include a statement notifying the Member they may exercise their right to request a State ~~h~~**H**earing in accordance with **California Code of Regulations,** ~~T~~**t**itle 22, ~~S~~**s**ections 50951, 51014.1, and 51014.2.

F. Contractor shall ensure that Members shall continue to receive care during the Grievance process.

G. Contractor shall ensure that there is no discrimination against a Member solely on the grounds that the Member filed a Grievance.

5. Discrimination Grievances

A. Contractor must designate a Section 1557/Civil Rights coordinator responsible for ensuring compliance with non-discrimination requirements and investigating grievances related to non-compliance with federal and state non-discrimination law. This includes language access complaints and complaints alleging failure to make reasonable accommodations under the ADA. Contractor must also adopt a process to ensure the prompt and equitable resolution of these discrimination-related grievances. Contractor shall submit the process to DHCS for review and approval prior to implementation.

B. Contractor's Section 1557/Civil Rights coordinator must be available to:

1) Answer questions and provide appropriate assistance to Contractor staff, Members and Applicants regarding Contractor's state and federal non-discrimination legal obligations;

2) Advise Contractor about non-discrimination best practices and accommodating persons with disabilities; and

3) Investigate and process discrimination grievances, including those alleging violations of the ADA, Section 504, Section 1557, and/or Government Code Section 11135.

C. Contractor shall use a template Notice of Non-Discrimination provided by DHCS to meet the obligation to post its discrimination grievance information as required by Section 1557 of the Affordable Care Act and its implementing regulations (45 CFR 92.8); Sections 14029.91 and 14029.92 of the Welfare and Institutions Code; and All Plan Letter (APL) 17-011, Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act (June 30, 2017), including any superseding All Plan Letter.

D. Within ten calendar days of mailing a discrimination grievance resolution letter to a Member or Eligible Beneficiary, Contractor must forward to the DHCS Office of Civil Rights (OCR) the following information regarding the discrimination grievance:

1. the original complaint;

2. the provider's or other accused party's response to the grievance;

3. contact information for the personnel responsible for the Contractor's response to the grievance;

4. contact information for the Member or Eligible Beneficiary and for the provider or other accused party that is the subject of the grievance;

5. all correspondence with the Member or Eligible Beneficiary regarding the grievance, including the grievance acknowledgment and grievance resolution letter(s) sent to the Member or Eligible Beneficiary; and

6. any other information that is relevant to the allegation of discrimination;

E. A Member, Eligible Beneficiary, or other interested person may file a discrimination grievance directly with DHCS OCR at any time.

Exhibit A, Attachment 14
Member Grievance and Appeals

Submission of a discrimination grievance to Contractor shall not be construed as a waiver of complainant's other rights regarding the allegedly discriminatory conduct, including the right to submit a grievance alleging discrimination in the Medi-Cal program directly to DHCS OCR or, as applicable, the United States Department of Health and Human Services Office for Civil Rights.

~~5~~6. Member Appeals Process

A. Contractor shall establish and maintain a procedure for submitting, documenting, processing, resolving, and evaluating all Member Appeals in accordance with federal PACE regulations 42 CFR, Sections 460.104(d)(2), 460.122, and 460.124**, 460.32(a)(6), and 460.154(n).**

B. In accordance with federal PACE regulation 42 CFR, Section 460.124, any Member whose Appeal is resolved or unresolved shall have the right to request a State ~~h~~**H**earing. Submission of a~~n~~ **Grievance and or an** Appeal shall not be construed as a waiver of the Member's right to request a State ~~h~~**H**earing in accordance **with California Code of Regulations** ~~T~~**t**itle 22, ~~CCR, S~~**s**ections 50951, 51014.1, 51014.2, and 53261.

~~6~~7. Member Notification of Denial, Deferral or Modification of Requests for Prior Authorization**, and Appeal**

A. Contractor shall notify Members of denial, deferral**,** or modification of request for Prior Authorization, in accordance with Title ~~22, CCR, Sections 51014.1 and 53261 by providing written notification to Members and/or their authorized representatives, regarding the denial, deferral or modification of a request or approval to provide health care services. These notifications must be provided per the timeframes specified in the federal PACE regulations 42 CFR, Sections 460.104(d)(2) and 460.122~~ **42 CFR 460.104 and 460.122.**

~~B. The written notification shall be given by Contractor to the Member and the Member's representative on a standardized form approved by DHCS and shall inform the Member of all the following:~~

~~1) The Member's right to and method for obtaining, a State hearing to contest the denial, deferral or modification action.~~

~~2) The Member's right to represent himself/herself at the State hearing or to be represented by legal counsel, friend or other spokesperson.~~

~~3) The name and address of Contractor and the State toll-free telephone number for obtaining information on legal service organizations for representation.~~

~~C. The notice to the Member may inform the Member that the Member may file an Appeal concerning Contractor's action using Contractor's Appeal process prior to or concurrent with the initiation of the State hearing process.~~

B. **If a member (or his or her designated representative) believes that the member needs to initiate, eliminate, or continue a particular service, the appropriate members of the interdisciplinary team, as identified by the interdisciplinary team, must conduct a reassessment. The interdisciplinary team member(s) may conduct the reassessment via remote technology when the interdisciplinary team determines that the use of remote technology is appropriate and the service request will likely be deemed necessary to improve or maintain the participant's overall health status and the participant or his or her designated representative agrees to the use of remote technology.**

An in-person reassessment must be conducted when participant or his or her designated representative declines the use of remote technology.

C. **The PACE organization must have explicit procedures for timely resolution of requests by a member or his or her designated representative to initiate, eliminate, or continue a particular service.**

D. **Except as provided in paragraph in E of this section, the interdisciplinary team must notify the member or designated representative of its decision to approve or deny the request from the member or designated representative as expeditiously as the member's condition requires, but no later than 72 hours after the date the interdisciplinary team receives the request for reassessment.**

E. **The interdisciplinary team may extend the 72–hour timeframe for notifying the member or designated representative of its decision to approve or deny the request by no more than 5 additional days for either of the following reasons:**

Exhibit A, Attachment 14
Member Grievance and Appeals

1) The member or designated representative requests the extension.

2) The team documents its need for additional information and how the delay is in the interest of the member.

F. The PACE organization must explain any denial of a request to the member or the member's designated representative orally and in writing. The PACE organization must provide the specific reasons for the denial in understandable language. The PACE organization is responsible for the following:

1) Informing the member or designated representative of his or her right to appeal the decision as specified in § 460.122.

2) Describing both the standard and expedited appeals processes, including the right to, and conditions for, obtaining expedited consideration of an appeal of a denial of services as specified in § 460.122.

3) Describing the right to, and conditions for, continuation of appealed services through the period of an appeal as specified in § 460.122(e).

4) If the interdisciplinary team fails to provide the member with timely notice of the resolution of the request or does not furnish the services required by the revised plan of care, this failure constitutes an adverse decision, and the member's request must be automatically processed by the PACE organization as an appeal in accordance with § 460.122.

Exhibit A, Attachment 15
Marketing

1. Marketing

Contractor shall comply with the requirements of 42 CFR 460.82 regarding marketing:

A. Information that a PACE organization must include in its marketing materials.

1) A PACE organization must inform the public about its program and give prospective members the following written information:

a. An adequate description of the PACE organization's Enrollment and Disenrollment policies and requirements.

b. PACE enrollment procedures.

c. Description of benefits and services.

d. Premiums.

e. Other information necessary for prospective members to make an informed decision about enrollment.

2) Marketing information must be free of material inaccuracies, misleading information, or misrepresentations.

B. Approval of marketing information.

1) CMS must approve all marketing information before distribution by the PACE organization, including any revised or updated material.

2) CMS reviews initial marketing information as part of an entity's application for approval as a PACE organization, and approval of the application includes approval of marketing information.

3) Once a PACE Organization is under a PACE program agreement, any revisions to existing marketing information and new information are subject to the following:

a. **Time period for approval. CMS approves or disapproves marketing information within 45 days after CMS receives the information from the organization.**

b. **Deemed approval. Marketing information is deemed approved, and the organization can distribute it, if CMS and the State administering agency do not disapprove the marketing material within the 45–day review period.**

C. Special language requirements

A PACE organization must furnish printed marketing materials to prospective and current members as specified below:

1) **In English and in any other principal languages of the community, as determined by the State in which the PACE organization is located. In the absence of a State standard, a principal language of the community is any language that is spoken in the home by at least 5 percent of the individuals in the PACE organization's service area.**

2) **In Braille, if necessary.**

D. Information on restriction of services

1) **Marketing materials must inform a potential member that he or she must receive all needed health care, including primary care and specialist physician services (other than emergency services), from the PACE organization or from an entity authorized by the PACE organization.**

2) **All marketing materials must state clearly that PACE members may be fully and personally liable for the costs of unauthorized or out–of–PACE program agreement services.**

E. Prohibited marketing practices

A PACE organization must ensure that its employees or its agents do not use prohibited marketing practices including but not limited to those prohibited Marketing practices listed in 42 CFR 460.82(e) and the following:

Exhibit A, Attachment 15
Marketing

1) Discrimination of any kind, except that marketing may be directed to individuals eligible for PACE by reason of their age.

2) Activities that could mislead or confuse potential members, or misrepresent the PACE organization, CMS, or the State administering agency.

3) Gifts or payments to induce enrollment, unless the gifts are of nominal value as defined in CMS guidance, are offered to all potential enrollees without regard to whether they enroll in the PACE program, and are not in the form of cash or other monetary rebates.

4) Marketing by any individual or entity that is directly or indirectly compensated by the PACE organization based on activities or outcomes unless the individual or entity has been appropriately trained on PACE program requirements.

a. PACE organizations are responsible for the activities of contracted individuals or entities who market on their behalf.

b. PACE organizations that choose to use contracted individuals or entities for marketing purposes must develop a method to document training has been provided.

5) Unsolicited door-to-door marketing or other unsolicited means of direct contact, including calling or emailing a potential or current participant without the individual initiating the contact.

~~1.~~**2.** Training and Approval of Marketing Representatives

Contractor shall develop an orientation and training program for Marketing Representatives and Marketing supervisors to ensure that all staff performing Marketing activities or distributing Marketing material are appropriately trained, have passed the DHCS' Medi-Cal Marketing exam and are approved by DHCS to conduct Marketing activities.

A. Contractor is responsible for all Marketing activities conducted on behalf of Contractor. Contractor shall be held liable for any and all violations by any Marketing Representative. Contractor shall ensure, in addition to compliance with the requirements of **California Code of Regulations,** ~~T~~title 22, ~~CCR,~~ ~~S~~sections 53400 through 53458 that:

Exhibit A, Attachment 15
Marketing

1) All Marketing Representatives, including supervisors, have satisfactorily completed Contractor's Marketing orientation and training program and the DHCS Marketing Representative Examination prior to engaging in Marketing activities on behalf of Contractor;~~.~~

2) Marketing Representative shall not provide Marketing services on behalf of more than one Contractor**; and** ~~.~~

3) Marketing Representatives do not engage in Marketing practices that discriminate against an eligible beneficiary because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual orientation, physical or mental handicap**,** or health status.

B. Training Program

1) Contractor shall develop a training and orientation program that shall train staff and prepare Marketing Representatives for the DHCS' Medi-Cal Marketing examination and to perform Marketing activities for Contractor. Contractor shall develop a staff orientation and Marketing Representative's orientation/training manual.

2) Contractor shall provide a memorandum of understanding~~,~~ **(**in the format provided by DHCS**)**~~,~~ that all Marketing Representatives must complete prior to taking the DHCS' Medi-Cal Marketing examination.

3) Contractor shall provide certification by Contractor that the Marketing Representatives have completed the orientation and training program

C. Marketing Presentations

Contractor shall ensure that all Marketing presentations made to eligible Members contain adequate information about Contractor to allow Members to exercise informed judgment in choosing to enroll in Contractor's plan. All Marketing presentations shall fully disclose the availability of and restrictions upon the services provided by Contractor. The information and procedures shall conform to **California Code of Regulations.** ~~T~~title 22, ~~CCR, S~~section 53404, and as a minimum, specify:

1) Scope, access to, and availability of services;

Back to Agenda Back to Item

2) An explanation of the requirements of confidentiality of any information obtained from Medi-Cal beneficiaries;~~.~~

3) An explanation of the nature of the Membership identification which shall authorize the Member to obtain services;~~.~~

4) An explanation that Members shall obtain all covered health care services required and rendered in non-emergency situations, through the plan's providers;~~.~~

5) An explanation that medical services required in an emergency may be obtained at all times from specified plan providers or from non-plan providers, if necessary;~~.~~

6) An explanation that Enrollment is voluntary;~~.~~

7) An explanation that Enrollment is subject to a verification or processing period of 15 to 45 days; and.

8) An explanation that Disenrollment is possible under the conditions specified in Title 22~~,~~ CCR~~,~~ Section 53440 and only after action by DHCS.

~~2~~3. DHCS Approval

A. Contractor shall not conduct Marketing activities without written approval of its Marketing plan from DHCS.

B. All Marketing materials, and changes in Marketing materials, including but not limited to, all printed materials, illustrated materials, videotaped, website, and media scripts, shall be approved in writing by DHCS prior to distribution.

C. Contractor's orientation and training program and changes in the orientation and training program shall be approved in writing by DHCS prior to implementation.

~~D. Contractor shall further comply with federal PACE regulation 42 CFR, Section 460.82(b).~~

~~3. **Marketing Plan**~~

Exhibit A, Attachment 15
Marketing

~~Contractor shall establish, implement, and maintain a Marketing plan approved by DHCS.~~

~~Contractor shall submit a Marketing plan to DHCS for review and approval on an annual basis. The Marketing plan, whether new, revised, or updated, shall describe Contractor's current Marketing procedures, activities, and methods. No new Marketing activity shall occur until the Marketing plan has been approved by DHCS.~~

~~A. The Marketing plan shall have a table of contents section that divides the Marketing plan into chapters and sections. Each page shall be dated and numbered so chapters, sections or pages, when revised, can be easily identified and replaced with revised submissions.~~

~~B. Contractor's Marketing plan shall contain the following items and exhibits:~~

~~1) Mission Statement or Statement of Purpose for the Marketing plan.~~

~~2) Organizational Chart and Narrative Description~~

~~a. The organizational chart shall include the Marketing director's name, address, telephone and facsimile number and key staff positions.~~

~~b. The description shall explain how Contractor's internal Marketing department operates, identifying key staff positions, roles and responsibilities, and reporting relationships.~~

~~3) Marketing Locations~~

~~All sites for proposed Marketing activities such as annual health fairs, and community events, in which Contractor proposes to participate, shall be listed.~~

~~4) Marketing Activities~~

~~All Marketing methods and Marketing activities Contractor expects to use or participate in, shall be described.~~

~~a. Contractor shall provide strict accountability, including documentation of a prospective Member's Marketing~~

~~presentation or a documented telephone log entry showing the request was made.~~

~~b. Include a letter or other document that verifies cooperation or agreement between Contractor and an organization to undertake a Marketing activity together and certify or otherwise demonstrate that permission for use of the Marketing activity/event site has been granted.~~

~~5) Marketing Materials~~

~~Copies of all Marketing materials Contractor shall use for both English and non-English speaking populations shall be included.~~

~~A sample copy of the Marketing identification badge and business card that shall clearly identify Marketing Representatives as employees of Contractor shall be included. The Marketing identification badge shall include:~~

~~a. Photograph of Marketing Representative (wallet size).~~

~~b. Name and job title of Marketing Representative.~~

~~c. Name, phone number and address of Contractor.~~

~~6) Marketing Distribution Methods~~

~~A description of the methods Contractor shall use for distributing Marketing materials.~~

~~7) Monitoring and Reporting Activities~~

~~Written formal measures to monitor performance of Marketing Representatives to ensure Marketing integrity pursuant to W&I Code, Section 14408(c).~~

~~8) Miscellaneous~~

~~All other information requested by DHCS to assess Contractor's Marketing program.~~

4. Signed Certifications

Exhibit A, Attachment 15
Marketing

A. Contractor shall provide a signed certification that Contractor shall abide by all Medi-Cal Marketing requirements and conditions.

B. Contractor shall provide a signed certification that all Marketing staff are employees of the Contractor.

5. **Medi-Cal Marketing Representative Reporting Requirements**

Contractor shall submit to DHCS a status of Marketing Representatives every three months.

6. **Mass Marketing Mailers**

Contractor may request mass market mailings of their Marketing material to Medi-Cal beneficiaries by using the mailing services provided by DHCS. Contractor shall notify DHCS 45 days in advance of the mailer being sent. Contractor shall be invoiced and all departmental costs associated to the mass mailing services shall be reimbursed to DHCS within 30 days of receipt of invoice.

~~7.~~ ~~**Prohibited Marketing Practices**~~

~~Contractor must ensure that its employees or its subcontractors do not use prohibited Marketing practices, and which include the following:~~

~~A. Contractor shall not engage in door to door or cold call Marketing for the purpose of enrolling Members or Potential Enrollees or for any other purpose.~~

~~B. Contractor shall not conduct Marketing presentations at Primary Care Sites.~~

~~C. Contractor shall not misrepresent themselves, Medicare or the Medi-Cal program through false advertising, false statements or activities that involve gifts or payments.~~

~~D. Contractor shall not Subcontract outreach efforts to individuals or organizations whose sole responsibility involves direct contact with the elderly to solicit enrollment.~~

~~E. Contractor shall be held responsible for any violations. Violations of this section shall include, but are not limited to, false or misleading claims, inferences or representations that:~~

Exhibit A, Attachment 15
Marketing

~~1) Marketing Representatives are employees or representatives of the State, county, or anyone other than the plan or Marketing organization by which they are reimbursed.~~

~~2) The plan is recommended or endorsed by any State agency or county agency or any other organization, which has not certified its endorsement of the plan in writing.~~

~~3) The State or county recommends that a Medi-Cal Member enroll in the plan.~~

~~4) Medi-Cal Member shall lose benefits under the Medi-Cal program or any other health or welfare benefits to which he/she is legally entitled if the Member does not enroll in a plan.~~

Exhibit A, Attachment 16
Enrollments and Disenrollments

1. Contractor shall comply with the Member Enrollment and Disenrollment requirements set forth in 42 CFR 460.150 through 460.172.

~~1~~2. Submittal of Enrollment and Disenrollment Files

Contractor shall submit Enrollments and Disenrollments in ~~the following manner:~~

~~Submit electronic Enrollments and Disenrollments to the DHCS' Information Technology Services Division, Data Guidance, via E-mail to hcptech@dhcs.ca.gov, and your designated contract manager, prior to the Managed Care Plan FAME cutoff processing schedule or any time after the first of the month~~ **accordance with PACE Policy Letter 20-01 and updates thereto**.

~~2~~3. Enrollment

Contractor shall accept as Members Medi-Cal beneficiaries voluntary aid categories as defined in Exhibit E, Attachment 1, Definitions, provision 35. ~~Eligible Beneficiaries.~~

A. ~~Enrollment:~~ - General

Eligible Medi-Cal beneficiaries residing within the approved service area of Contractor, as defined in Exhibit E, Attachment I, provision 92~~.~~**,** may voluntarily apply for Enrollment under this Contract at any time during the term of this Contract. **Beneficiaries meeting the eligibility requirements of 42 CFR 460.150** ~~Eligible beneficiaries~~ shall be accepted by Contractor in the order in which they apply and without regard to ~~physical~~ **health status** or mental condition **disability**, age, ~~sex~~ **gender**, race, religion, creed, color, national origin, marital status, sexual orientation**,** or ancestry.

Eligibility to enroll in a PACE program is governed by 42 CFR 460.150, which states:

1) General rule. To enroll in a PACE program, an individual must meet eligibility requirements specified in this section. To continue to be eligible for PACE, an individual must meet the annual recertification requirements specified in Section 460.160.

2) Basic eligibility requirements. To be eligible to enroll in PACE, an individual must meet the following requirements:

a. be 55 years of age or older;

b. be determined by the State administering agency to need the level of care required under the State Medicaid plan for coverage of nursing facility services, which indicates that the Individual's health status is comparable to the health status of individuals who have participated in the PACE demonstration waiver programs;

c. reside in the service area of the PACE organization; and

d. meet any additional program specific eligibility conditions imposed under the PACE program agreement. These additional conditions may not modify the requirements of paragraph (b)(1) through (b)(3) of this section.

3) Other eligibility requirements.

a. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety

b. The criteria used to determine if an individual's health or safety would be jeopardized by living in a community setting must specified in the program agreement.

i) Eligibility under Medicare and Medicaid. Eligibility to enroll in a PACE program is not restricted to an individual who is either a Medicare beneficiary or Medicaid beneficiary. A potential PACE enrollee may be, but is not required to be, any or all of the following:

(1) entitled to Medicare Part A;

(2) enrolled under Medicare Part B; and/or

(3) eligible for Medicaid.

To be eligible for payment under this Contract, the individual must be eligible for Medi-Cal.

Exhibit A, Attachment 16
Enrollments and Disenrollments

The enrollment process to be followed by Contractor is set forth in 42 CFR 460.152. The enrollment agreement must comply with the requirements of 42 CFR 460.154. Other enrollment procedures set forth in 42 CFR 460.156.

B. Coverage

1) A member's enrollment in Contractor's PACE plan is effective on the first day of the calendar month following the date Contractor receives the signed enrollment agreement, as provided by 42 CFR 460.158. The member's continuation of enrollment is governed by the requirements of 42 CFR 160. The term of ~~Membership~~ **enrollment** shall continue indefinitely unless this Contract expires, is terminated or the Member is disenrolled under the conditions described in provision ~~3~~**4** ~~of this Attachment~~.

2) Enrollment is contingent ~~upon completion of a designation form in compliance with requirements of W&I Code, Section 14088(c) and~~ continued financial eligibility **for Medi-Cal,** and initial eligibility for long-term care as determined by DHCS.

3) The member's eligibility for long-term care must be reevaluated by DHCS at least annually, unless DHCS determines there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the severity of chronic condition, or degree of impairment of functional capacity of the member. A member may be deemed to continue to be eligible for the PACE program notwithstanding a determination that the individual no longer nursing facility level of care if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period. (42 USC 1395eee(c)(3) and (4).) As provided by 42 CFR 460.160:

a. DHCS may permanently waive the annual recertification requirement for a member if it determines that there is no reasonable expectation of improvement or significant change in the member's condition because of the

severity of a chronic condition or the degree of impairment of functional capacity.

b. Contractor must retain in the member's medical record the documentation of the reason for waiving the annual recertification requirement.

c. If DHCS determines that a PACE member no longer meets the Medi-Cal nursing facility level of care requirements, the member may be deemed to continue to be eligible for the PACE program until the next annual reevaluation, if, in the absence of continued coverage under this program, the member reasonably would be expected to meet the nursing facility level of care requirement within the next 6 months.

DHCS has establish criteria to use in making the determination of "deemed continued eligibility." DHCS, in consultation with Contractor, makes a determination of deemed continued eligibility based on a review of the member's medical record and plan of care. These criteria must be applied in reviewing the member's medical record and plan of care. In accordance with PACE Policy Letter 02-14 and updates thereto.

C. Information to Prospective Members

Contractors must i Inform each Medi-Cal Member signing an Enrollment ~~application~~ **Agreement**, in writing, of the following:

1) ~~There is a 15 to 45-day processing period between the date the Enrollment application is received by Contractor and the date Contractor receives written notice from the DHCS that the Member has been enrolled.~~ **Member enrollment will be effective on the first day of the month following Contractor submission of the Enrollment Agreement to DHCS.**

~~2) Official Enrollment in Contractor's plan is not effective until processing is completed by DHCS.~~

~~3~~**2**) ~~A Member may D~~Disenroll upon request, without having to provide a reason for the request, at any time after the

~~effective date of Enrollment.~~ **At any time, a member may request to disenroll from the PACE Organization, without having to provide a reason for the request. The disenrollment will be effective the first day of the month following the date the PACE Organization receives the request.**

~~3~~4. Disenrollment

~~Disenrollment may take place under the following conditions subject to approval by DHCS in accordance with the provisions of Title 22, CCR, Section 53440~~

As required by 42 CFR 460.172, Contractor must have a procedure in place to document the reasons for all voluntary and involuntary disenrollments. Contractor must make that documentation available for review by CMS and DHCS. Contractor must use the information on voluntary disenrollments in the PACE organization's internal quality improvement program.

A. Voluntary Disenrollment

1) A member's voluntary disenrollment is effective on the first day of the month following the date the PACE organization receives the member's notice of voluntary disenrollment.

2) A PACE member may voluntarily disenroll from the program without cause at any time.

3) The Contractor must ensure that its employees or contractors do not engage in any practice that would reasonably be expected to have the effect of steering or encouraging disenrollment of participants due to a change in health status.

B. Involuntary Disenrollment

A member's involuntary disenrollment occurs after the Contractor meets the requirements set forth in this section and is effective on the first day of the next month that begins 30 days after the day the PACE organization sends notice of the disenrollment to the member.

As provided in 42 CFR 460.164, Contractor may involuntarily disenroll a member for any of the following reasons:

Exhibit A, Attachment 16
Enrollments and Disenrollments

1) The member, after a 30-day grace period, fails to pay or make satisfactory arrangements to pay any premium due to the Contractor;

2) The member, after a 30-day grace period, fails to pay or make satisfactory arrangements to pay any applicable Medi-Cal spenddown liability or any amount due under the post-eligibility treatment of income process, as permitted under §§460.182 and 460.184;

3) The member, or the member's caregiver engages in disruptive or threatening behavior, and exhibits either of the following:

   a. A member whose behavior jeopardizes his or her health or safety, or the safety of other; or

   b. A member with decision-making capacity who consistently refuses to comply with his or her individual plan of care or the terms of the PACE enrollment agreement.

   c. A member's caregiver who engages in disruptive or threatening behavior exhibits behavior that jeopardizes the member's health or safety, or the safety of the caregiver or others.

   The Conractor may not disenroll a member on the grounds that the participant has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the participant, unless the participant's behavior jeopardizes his or her health or safety, or the safety of others. Noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments.

4) The member moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the Contractor agrees to a longer absence due to extenuating circumstances;

5) The member is determined to no longer meet the State Medicaid nursing facility level of care requirements and is not deemed eligible;

Exhibit A, Attachment 16
Enrollments and Disenrollments

6) The Contractor's agreement with CMS and DHCS is not renewed or is terminated; and

7) The Contractor is unable to offer health care services due to the loss of State licenses or contracts with outside providers.

~~A. Disenrollment of a Member is mandatory when:~~

~~1) The member requests Disenrollment.~~

~~2) The Member's eligibility as a Medi-Cal beneficiary is ended, including the death of the Member or eligibility for Enrollment in the plan is terminated.~~

~~3) There is a change of a Member's place of residence to outside Contractor's Service Area or the Member is out of the area for more than 30 consecutive days, unless Contractor agrees to a longer absence due to extenuating circumstances.~~

~~4) The Member is determined to no longer meet the State Medicaid nursing Facility level of care requirements and is not deemed eligible.~~

~~5) Member is repeatedly verbally abusive to Contracted providers, ancillary or administrative staff, subcontractor staff or to other plan Members.~~

~~6) Member physically assaults a Contracted provider or staff person, subcontractor staff person or other Member or threatens another individual with a weapon on Contractor premises or subcontractor's premises. In this instance, Contractor or subcontractor shall file a police or security agency report and file charges against the Member.~~

~~7) Member who engages in disruptive or threatening behavior and exhibits either of the following:~~

~~a. Jeopardizes his (her) own health or safety or the safety of others; or~~

~~b. Member with a decision-making capacity who consistently refuses to comply with his (her) individual plan of care or the terms of Contractor's Enrollment Agreement.~~

Exhibit A, Attachment 16
Enrollments and Disenrollments

~~8) Member fails to pay, or make satisfactory arrangements to pay, any premium due Contractor after a 30-day grace period.~~

~~9) Member has allowed the fraudulent use of Medi-Cal coverage under the plan, which includes allowing others to use the Member's plan Membership card to receive services from Contractor.~~

~~10) Contract with the State is not renewed or terminated.~~

As required by 42 CFR 460.166, in disenrolling a member, Contractor must use the most expedient process allowed as set forth in this Contract, coordinate the disenrollment date between Medicare and Medicaid (for a member who is eligible for both Medicare and Medicaid), and give reasonable advance notice to the member. Until the date enrollment is terminated, members must continue to use PACE organization. Contractor must continue to furnish all needed services until the date of disenrollment.

~~B. The problem resolution attempted prior to a Contractor-initiated Disenrollment described in paragraph B must be documented by Contractor~~. **Contractor shall establish a** formal procedure for Contractor-initiated **involuntary** Disenrollments ~~shall be established by Contractor and~~ **that meets the approval of DHCS** ~~approved by DHCS~~. As part of the procedure, the Member shall be notified in writing by Contractor of the intent to ~~d~~**D**isenroll the Member for cause and allowed a period of no less than 20 days to respond to the proposed action.

~~1)~~**C** Contractor must submit a written request for Disenrollment and the documentation supporting the request to DHCS for approval. The supporting documentation must establish **the reason for proposing to involuntary disenroll the member and all efforts to remedy the situation.** ~~the pattern of behavior and Contractor's efforts to resolve the problem.~~ DHCS shall review the request and render a decision in writing within **ten** ~~(10)~~ State working days of receipt of a Contractor request and necessary documentation. If **Contractor-initiated** ~~the~~ request **for Disenrollment** is approved **by DHCS**, DHCS shall process the Disenrollment. Contractor shall be notified by DHCS of the decision, and if the request is granted, shall be notified of the effective date of the Disenrollment. Contractor shall notify the Member of the Disenrollment for cause **(involuntary disenrollment)** if DHCS grants Contractor-initiated request for Disenrollment.

Exhibit A, Attachment 16
Enrollments and Disenrollments

~~2)~~ ~~Contractor shall continue to provide Covered Services to the Member until the effective date of the Disenrollment.~~

~~E~~**D.** Membership shall cease **no later than** ~~at~~ midnight on the last day of the **first** calendar month **after** ~~in which~~ the ~~Member's~~ **Contactor's** Disenrollment request **and all required supporting documentation** ~~is approved~~ **are received** by DHCS. On the first day **after Enrollment ceases,** ~~of the month following the approval of the Disenrollment request,~~ Contractor is relieved of all obligations to provide Covered Services to the Member under the terms of this Contract. Contractor ~~agrees in turn to~~ **shall** return to DHCS any Capitation payment forwarded to Contractor for persons not enrolled under this Contract.

E. In the case of an individual whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), Contractor shall provide assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers, and take action in compliance 42 CFR 460.168 to facilitate the individual's reinstatement in other Medicare and Medicaid programs. Contractor may reinstate a previously enrolled member.

Exhibit A, Attachment 17
Reporting Requirements

1. Contractor shall furnish the following reports and information to the DHCS and/or ~~LTCD~~ **ISCD** (unless specifically exempted from reporting **by DHCS** ~~pursuant to W&I Code, Section 14308~~):

   A. On an annual basis:

      1) The ~~F~~**f**inancial audit report ~~required by W&I Code, Section 14459~~. **in compliance with this Exhibit A, Attachment 2, provision 2.** This report shall be submitted to the DHCS no later than ~~120~~ **180** calendar days after the close of Contractor's fiscal year~~.~~**;**

      2) A disclosure statement in compliance with this Exhibit A, Attachment 1, provision 2A~~.~~**;**

      3) Facility aggregate report for ~~Service Sites~~ **PACE Centers** and Contracted Providers~~.~~**;**

      4) Enrollment Agreement: Terms and Conditions update~~.~~**;**

      5) Results of Member satisfaction surveys~~.~~**;**

      6) Contractor shall submit an updated Contracted Provider Directory, which**,** at a minimum**,** contains the following information:

         a. ~~H~~**h**eaders to indicate city or region names (in alphabetical order)**;**

         b. ~~S~~**s**pecialty (e.g. Optometry)**;**

         c. ~~P~~**p**rovider's name (last, first-listed alphabetically)**;**
            Street address
            City including zip codes
            Telephone number including area code

         d. ~~L~~**l**anguages (other than English) spoken at the provider site**; and**

         e. ~~M~~**m**edical Group/Institutional/Specialty name (e.g. University of California)

      7) Summary of all Quality Assurance activities~~.~~**;**

Exhibit A, Attachment 17
Reporting Requirements

8) Progress report of major events, program applications and developments, research activities and administration. The report shall include, but not be limited to, Member demographic characteristics; medical diagnosis by disease categories**,** and physical, cognitive**,** and functional status; member/program census, service cost and utilization statistics, difficulties or special problems, pertinent facts**,** or interim findings. Submit copy of progress report to CMS if different ~~than~~ **from** above~~.~~**;**

9) Financial reports relevant to affiliates as specified in **California Code of Regulations,** ~~T~~**t**itle 22, ~~CCR,~~ ~~S~~**s**ection 53330~~.~~**;**

10) Copies of any financial reports submitted to other public or private organizations as specified in **California Code of Regulations** ~~T~~**t**itle 22, ~~CCR~~, ~~S~~**s**ection 53324 **,subdivision** (d)~~.~~**;**

11) Additions and deletions to Marketing Representative staff~~.~~**;**

12) Summary of Member Grievances, Appeals, and Unusual Incidents**;**

13) Summary of Provider Grievances**; and**

14) Listing of all Contractor's Subcontract providers which includes a listing of new ~~s~~**S**ubcontractors and those contracts terminated during the quarter

B. On a quarterly basis (within ~~45~~ **forty-five** calendar days of the end of each quarter under this Contract):

1) Utilization and statistical data in compliance with **California Code of Regulations** ~~T~~**t**itle 22, ~~CCR,~~ ~~S~~**s**ection 53314 in accordance with the reporting format approved by DHCS.

2) Financial reports required by **California Code of Regulations** ~~T~~**t**itle 22, ~~CCR,~~ ~~S~~**s**ection 53324 **subdivision** (c), unless waived in writing by the Department.

2. Other reports to be submitted to the DHCS include:

A. information requested by the DHCS to conduct medical, financial, Contract monitoring, and review activities in accordance with W&~~I~~**elfare and Institutions** Code, ~~S~~**s**ections 14456 and 14457~~.~~**;**

Exhibit A, Attachment 17
Reporting Requirements

B. results of Quality of Care studies and/or progress reports shall be submitted every six months~~.~~**;**

C. new and revised Contractor's policies and procedures ~~on an ongoing basis.~~ **upon the request of DHCS;**

D. notification of possible Third-Party Tort Liability situations, including Workers' Compensation situations. This information shall be submitted within ~~10~~ **ten** calendar days of discovery~~.~~**;**

E. names of Contractor's employees who are subject to the requirements of **California Code of Regulations** ~~T~~**t**itle 22~~,~~ CCR~~,~~ ~~S~~**s**ection 53600 **,subdivision** (f). This information shall be reported to the Department within ~~10~~ **ten** days of the employment date~~.~~**;**

F. information necessary for evaluation of compliance with **California Code of Regulations** ~~T~~**t**itle 22, ~~CCR,~~ ~~S~~**s**ection 53402~~.~~**;**

G. a completed ~~D~~**d**isclosure ~~S~~**s**tatement at the time the Contract is executed, annually with Contractor's Certified Public Accountant audit and financial statement, and within ~~35~~ **thirty-five** days of a written request by DHCS or DHHS of any change in previously submitted information~~.~~**;**

H. contractor shall notify DHCS within ~~10~~ **ten** days of any changes in key personnel pursuant to PACE Policy Letter 06-03~~.~~**;**

I. contractor shall notify DHCS of Disenrollments that have occurred after MEDS/FAME processing cut-off date for hard copy submissions due to deaths and/or out of Service Area~~.~~**; and**

J. contractor shall submit to DHCS a monthly report listing all active Members as of the first day of the month including pertinent Medi-Cal, Medically Needy Only/Share of Cost and Medicare eligibility information for each Member. The reports shall also include a listing of all new (additions) and terminating (deletions) Member activity for the month, and the reason for any listed terminations.

K. Submittal of Inpatient Days Information

Upon DHCS' written request, Contractor shall report hospital inpatient days to DHCS as required by Welfare and Institutions Code, Section 14105.985(b)(2) for the time period and in the form

Exhibit A, Attachment 17
Reporting Requirements

and manner specified in DHCS' request, within 30 calendar days of receipt of the request. Contractor shall submit additional reports to DHCS, as requested, for the administration of the disproportionate share hospital program.

Exhibit B
Budget Detail and Payment Provisions

Budget Detail and Payment Provisions

1. Budget Contingency Clause

2. Amounts Payable

3. Contractor Risk in Providing Services

4. Capitation Rates

5. Capitation Rates Constitute Payment in full

6. Determination of Rates

7. Redetermination of Rates-Obligation Changes

8. Reinsurance

9. Catastrophic Coverage Limitation

10. Financial Performance Guarantee

11. Recovery of Capitation Payments

12. Requirements for Payments of Retroactive Capitation (Retrocapitation) for Eligible Members

Exhibit B
Budget Detail and Payment Provisions

1. Budget Contingency Clause

A. It is mutually agreed that if the Budget Act of the current year or any subsequent years covered under this Agreement does not appropriate sufficient funds for the program, the State shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this ~~Agreement~~ **Contract**, and Contractor shall not be obligated to perform any provisions of this ~~Agreement~~ **Contract**. Further, should funding for any fiscal year be reduced or deleted by the Budget Act for purposes of this program, the State shall have the option to:

1) Cancel this ~~Agreement~~ **Contract** with no liability occurring to the State and no further obligation by Contractor to perform, or

2) Offer a~~n agreement~~ **contract** amendment to Contractor to reflect the reduced amount.

B. All payments and rate adjustments are subject to appropriations of Medi-Cal funds by the Legislature and may require Department of Finance approval. Further, all payments are subject to the availability of Federal congressional appropriation of funds.

2. Amounts Payable

Any requirement of performance by the State and Contractor for the period of the Contract will be dependent upon the availability of future appropriations by the Legislature for the purpose of the Medi-Cal program.

~~2~~3. Contractor Risk In Providing Services

Contractor shall assume the total risk of providing the Covered Services on the basis of the periodic Capitation payment for each Member, except as otherwise allowed in this Contract. Any monies not expended by Contractor after having fulfilled obligations under this Contract shall be retained by Contractor.

~~3~~4. Capitation Rates

A. The State shall remit to Contractor a Capitation payment ~~for each Member,~~ for each month **for each Medi-Cal Member that** ~~in which such Member is eligible for Medi-Cal benefits and~~ appears on the approved list of Members supplied to Contractor by DHCS. **The capitation rate shall be the amount specified in Exhibit B, Attachment 1, Rate of Medi-Cal Reimbursement. The payment period for health care services shall**

commence on the first day of operations, as determined by DHCS. Capitation payments shall be made in accordance with the schedule of capitation payment rate ~~Contractor shall be paid Capitation~~ at the end of each month. **For aid codes see DEFINITION, Eligible Beneficiary.**

~~A~~**B**. For Share of Cost Members, payment shall be made at the end of the month following certification by Contractor that the Member's Share of Cost has been collected and cleared through the DHCS' Point of Service device prior to the first calendar date listed on DHCS' Managed Care Plan FAME Cut-Off/Processing Schedule.

~~B~~**C**. If DHCS creates a new aid code that is split or derived from an existing aid code covered under this Contract, and the aid code has a neutral revenue effect for Contractor, then the split aid code shall automatically be included in the same aid code rate group as the original aid code covered under this Contract. Contractor agrees to continue providing Covered Services to the Members at the monthly Capitation Rate specified for the original aid code. DHCS shall confirm all aid codes splits, and the rates of payment for such new aid codes, in writing to Contractor as soon as practicable after such aid code splits occur.

~~C~~**D**. Capitation payments shall be made in accordance with the schedule of Capitation Rates set forth in Exhibit B, Attachment 1, Rate of Medi-Cal Reimbursement~~, and Exhibit B, Attachment 2, Capitation Rate Worksheet(s)~~.

4**5**. Capitation Rates Constitute Payment In Full

~~The Capitation payment constitutes payment in full by the DHCS on behalf of a Member for all Covered Services required by such Member, subject to the provisions of Exhibit E, Attachment 3, provision 8. Risk Limitation, and for all administrative costs incurred by Contractor in providing or arranging for such services, but does not include payment for the recoupment of current or previous losses incurred by Contractor. The basis for the determination of the Capitation payment rates is outlined in Exhibit B, Attachment 1, Rate of Medi-Cal Reimbursement.~~

Capitation rates for each rate period, as calculated by DHCS, are prospective rates and constitute payment in full, subject to any stop loss reinsurance provisions, on behalf a Member for all Covered Services required by such Member and for all Administrative Costs incurred by the Contractor in providing or arranging for such services. DHCS is not responsible for making payments for recoupment of losses.

Exhibit B
Budget Detail and Payment Provisions

~~5~~6. Determination Of Rates

A. DHCS shall determine the capitation rates on a yearly basis. DHCS shall make an annual redetermination of rates for each rate year defined as the 12-month period from January 1 through December 31. DHCS shall attempt to negotiate rates in good faith for each rate year in accordance with Title 42, CFR, Section 460.182. DHCS reserves the right to establish rates on an actuarial basis for each rate year which it shall do in accordance with Welfare and Institutions Code Section 14301.1(n), and Title 42, CFR, Sections 438.6 and 460.182. All payments and rate adjustments are subject to appropriations of funds by the Legislature and the Department of Finance approval. Further, all payments are subject to the availability of Federal congressional appropriation of funds.

B. Once DHCS establishes rates on an actuarial**ly sound** basis, it shall determine whether the rates shall be increased, decreased, or remain the same. If it is determined by DHCS that Contractor's capitation rates shall be increased or decreased, the increase or decrease shall be effectuated through ~~the~~ **an** amendment ~~process~~ **to this contract in accordance with the provisions of Exhibit E, Attachment 2, Provision 3. Amendment Process.** Change orders shall be utilized in the event that DHCS and the Contractor cannot reach an agreement. Negotiations may still continue and the Contractor may initiate a dispute in accordance with Exhibit E, Attachment 2, Provision 18, Disputes and retains the right to terminate the contract is unable to reach agreement with DHCS. A change order to this Contract shall be in accordance with W&I Code Section 14301(c) and the provision of Exhibit E, Attachment 2, provision 4, Change Requirements, subject to the following:

1) The amendment or change order shall be effective as of January 1 of each year covered by this Contract.

2) In the event there is any delay in a determination to increase or decrease capitation rates, so that an amendment or change order may not be processed in time to permit payment of new rates commencing January 1, the payment to Contractor shall continue at the rates stated in an R Letter sent to the Contractor by DHCS. The R Letter shall serve as notification from DHCS to Contractor of the capitated rates, and the time period for which these rates will be applied. The R Letter shall not be considered exempt from any requirement of this Contract. Those continued payments shall constitute interim payment only. Upon final approval of the amendment or change order providing for the rate change, DHCS

Back to Agenda Back to Item

shall make retroactive adjustments for those months for which interim payment was made.

3) By accepting payment of new annual rates prior to full approval by all control agencies of the amendment or change order to this Contract implementing such new rates, Contractor stipulates to a confession of judgment for any amounts received in excess of the final approved rate. If the final approved rate differs from the rates established by DHCS or agreed upon by Contractor and DHCS:

   a. Any underpayment by the State shall be paid to Contractor within 30 **calendar** days after final approval of the new rates.

   b. Any overpayment to Contractor shall be recaptured by the State's withholding the amount due from Contractor's next capitation check. If the amount to be withheld from that capitation check exceeds 25 percent of the capitation payment for that month, amounts up to 25 percent shall be withheld from successive capitation payments until the overpayment is fully recovered by the State.

4) If **mutual agreement between DHCS and** the Contractor **cannot be attained on** ~~does not accept the c~~**C**apitation rates for subsequent rate years ~~resulting from a rate change pursuant to this Contract, then the~~ Contractor shall retain the right to terminate the Contract. Notification of intent to terminate a Contract shall be in writing and provided to DHCS at least nine months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with Exhibit E, Attachment 2, provision 14. ~~Termination for Cause and Other Terminations.~~ DHCS shall pay the ~~c~~**C**apitation rates last offered for that rate period until the Contract is terminated.

5) DHCS shall make every effort to notify and consult with Contractor regarding proposed redetermination of rates pursuant to this section or provision 7 below at the earliest possible time prior to implementation of the new rate.

~~6~~7. Redetermination ~~O~~of Rates: Obligation Changes

The Capitation Rates may be adjusted during the rate year to provide for a change in obligations ~~which~~ **that** results in an increase or decrease **of more than one percent of** ~~in~~ costs (~~as defined in~~ **California Code of Regulations title 22**

Section 53869) to **the** Contractor~~, in accordance with the provisions of W&I Code, Section 14301(c) and regulations adopted thereunder~~. Any ~~such~~ adjustment**s** shall be effectuated through an amendment ~~or change order~~ to this Contract ~~in accordance with the provisions of Exhibit E, Attachment 2, provision 3. Amendment Process,~~ subject to the following provisions:

A. The amendment ~~or change order~~ shall be effective as of the first day of the month in which the change in obligations is effective, as determined by DHCS.~~;~~ **; and**

B. In the event DHCS is unable to process the amendment ~~or change order~~ in time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor shall continue at the rates then in effect. ~~Such c~~**C**ontinued payment shall constitute interim payment only. Upon final approval of the amendment ~~or change order~~ providing for ~~such~~ **the** change in obligations, DHCS shall make adjustments for those months for which interim payment was made.

~~C.~~ ~~Change orders shall be utilized in the event that DHCS and the Contractor cannot reach an agreement. Negotiations may still continue and the Contractor may also initiate a dispute in accordance with Exhibit E, Attachment 2, Provision 18, Disputes and retains the right to terminate the contract if unable to reach agreement with DHCS. A change order to this Contract shall be in accordance with W&I Code Section 14301(c) and the provisions of Exhibit E, Attachment 2, Provision 4, Change Requirements~~.

~~D~~**C**. DHCS and Contractor may negotiate an earlier termination date, pursuant to Exhibit E, Attachment 2, ~~P~~**p**rovision 14, ~~Termination for Cause and Other Terminations~~, if a change in contractual obligations is created by a State or Federal change in the Medi-Cal program, or a lawsuit, that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this provision.

~~7~~8. Reinsurance

Contractor may obtain Reinsurance (stop loss coverage) ~~or may self-insure upon approval by DHCS~~ to ensure maintenance of adequate capital by Contractor, for the cost of providing Covered Services under this Contract. Pursuant to **California Code of Regulation** ~~T~~**t**itle 22, ~~CCR~~, ~~S~~**s**ection 53252 (a)(2)(A) &(B), Reinsurance shall not limit Contractor's liability below $5,000 per Member for any

12-month period as specified by DHCS, and Contractor may obtain Reinsurance for the total cost of services provided to Members by non-Contractor emergency service providers and for 90 percent of all costs exceeding 115 percent of its income during any Contractor fiscal year.

~~8~~9. Catastrophic Coverage Limitation

DHCS may limit Contractor's liability to provide or arrange and pay for care for illness of or injury to Members, which results from or is greatly aggravated by, a catastrophic occurrence or disaster. Contractor shall return a prorated amount of the Capitation payment following the DHCS Director's invocation of the catastrophic coverage limitation. The amount returned ~~shall~~ **will** be determined by dividing the total Capitation payment by the number of days in the month. The amount ~~shall~~ **will** be returned to DHCS for each day in the month after the Director has invoked the catastrophic coverage limitation clause.

~~9~~10. ~~This provision intentionally left blank.~~ Financial Performance Guarantee

Contractor shall provide satisfactory evidence of, and maintain Financial Performance Guarantee in, an amount equal to at least one month's capitation payment, in a manner specified by DHCS. At the Contractor's request, and with DHCS approval, Contractor may establish a phase-in schedule to accumulate the required Financial Performance Guarantee. Contractor may elect to satisfy the Financial Performance Guarantee requirement by receiving payment on a post payment basis. The Financial Performance Guarantee shall remain in effect for a period not exceeding 90 calendar days following termination or expiration of this Contract unless DHCS has a financial claim against Contractor. Further rights and obligations of the Contractor and DHCS, in regards to the Financial Performance Guarantee, shall be as specified in California Code of Regulations title 22 section 53865.

~~10~~11. Recovery Of Capitation Payments

DHCS shall have the right to recover **from Contractor** amounts paid to Contractor in the following circumstances as specified:

A. If DHCS determines that a Member has either been improperly enrolled, due to ineligibility of the Member to enroll in Contractor's plan, residence outside of Contractor's Service Area or pursuant to **California Code of Regulations** ~~T~~title 22, ~~S~~section 53440(a)(2) or should have been disenrolled with an effective date in a prior month. DHCS may recover the Capitation payments made to Contractor for the Member for the months in

question**. To the extent permitted by law**, Contractor may seek to recover any payments made to providers for Covered Services rendered for the month(s) in question. Contractor shall inform providers that claims for services provided to Members during the month(s) in question ~~shall~~ **may** be paid by the DHCS~~'~~ fiscal intermediary, if the Member is determined eligible for the Medi-Cal program.

Upon request by Contractor, DHCS may allow Contractor to retain the capitation payments made for Members that are eligible to enroll in Contractor's plan, but should have been retroactively disenrolled pursuant to Exhibit A, Attachment 11, Provision 18. Excluded Services Requiring Member Disenrollment, or under other circumstances as approved by DHCS. If Contractor retains the capitation payments, Contractor shall provide or arrange and pay for all Medically Necessary Covered Services for the Member, until the Member is disenrolled on a nonretroactive basis pursuant to Exhibit A, Attachment 16, provision 4.

B. As a result of Contractor's failure to perform their contractual responsibilities to comply with mandatory federal Medicaid requirements, the ~~Federal Department of Health and Human Services~~ ~~(~~DHHS~~)~~ may disallow Federal Financial Participation (FFP) for payments made by DHCS to Contractor. DHCS may recover the amounts disallowed by DHHS by an offset to the Capitation payment made to Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, DHCS, at its discretion may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six ~~(~~6~~)~~ months.

~~C. DHCS determines that an improper or erroneous AIDS claim payment has been made to Contractor. Improper or erroneous AIDS claim payments shall be recovered by the DHCS in conformance with this Exhibit.~~

~~D~~**C**. ~~The~~ DHCS determines that any other erroneous or improper payment not mentioned above has been made to Contractor. DHCS may recover the amounts determined by an offset to the Capitation payment made to Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, DHCS, at its discretion, may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six ~~(~~6~~)~~ months. At least 30 days prior to seeking any such recovery, DHCS shall notify Contractor to explain the improper or erroneous nature of the payment and to describe the recovery process.

Exhibit B
Budget Detail and Payment Provisions

~~11~~12. Requirements for Payments of Retroactive Capitation (Retrocapitation) for Eligible Members

A. Contractor may submit to DHCS a request for payment of retroactive Capitation payments for Members that continued to receive all services offered by the PACE plan, but for whom Capitation payments were not made by DHCS due to the Member's eligibility being placed on hold status. Requests for retrocapitation payments shall be made immediately upon clearance of the Member's eligibility status or no later than 30 days after the Member's eligibility status has been restored. Retrocapitation payments are subject to the discretion of the Department, and will be made only if all of the following conditions have been met:

1) Contractor's request for payment of retrocapitation must provide adequate and sufficient verifiable documentation for each request, including all information requested by DHCS;

2) Enrollment in the PACE plan has been verified through MEDS for each month retrocapitation payments are being requested;

3) During the period for which Contractor is requesting a retrocapitation payment, the Contractor has continued to satisfactorily demonstrate that the plan reconciles and reports eligibility for all Members on a monthly basis using the FAME report as well as supplemental reports submitted by ~~the~~ Medi-Cal Managed Care ~~Division~~;

4) The request for retrocapitation payments for ~~participants~~ **members** with a previous unmet share of cost has been reconciled and submitted on a monthly basis In accordance with Exhibit B, ~~P~~ **p**rovision 3, ~~Capitation Rates~~; and

5) Contractor is, in the ~~Department's~~ **DHCS'** determination, in substantial compliance with all contractual requirements at the time a request for retrocapitation is made.

B. Retrocapitation payment requests shall be made within 30 days from the end of the month during which the Member for whom retrocapitation payments are being requested has had their eligibility status removed from hold status. Under no circumstances will the ~~Department~~ **DHCS** consider retrocapitation payment requests more than six months from the time the Member's eligibility status has been restored.

Back to Agenda Back to Item

Exhibit B
Budget Detail and Payment Provisions

C. All decisions by DHCS with respect to approval or denial of a request for retrocapltatlon shall be final.

D. Documentation ~~that may be~~ required to be submitted by the PACE plan includes, but is not limited to the following:

1) Medi-Cal Eligibility Verification from Point of Service (POS) device and/or Notice of Action issued from the County for the requested month(s) of retrocapitation;

2) HCP FAME Record displaying the Member's eligibility and HCP status, with the months for which retrocapitation is requested highlighted;

3) All Batch Transmittals, Enrollment Form and Agreement submitted to DHCS for processing, including initial enrollment documents and resubmitted documents;

4) Letter from the County in which the Member resides providing verification of county residence and date of residency; and

5) Monthly share of cost listing for the requested month(s) of retrocapitation, with the Member's name and share of cost amount highlighted.

E. For the purpose of processing retrocapitation requests, DHCS shall have available and shall provide to Contractor upon request, a form for Contractor to use when submitting to DHCS all required Member information for DHCS to review in support of Contractor's request for retrocapitation.

PACE Plan Name
Contract Number

Exhibit B, Attachment 1
Rate of Medi-Cal Reimbursement

Federal regulation (42 CFR 460.182) requires that the state makes monthly capitation payments to PACE organization for Medi-Cal participants which are less than the amount that would otherwise have been paid (AWOP) under the State plan if those participants were not enrolled in the PACE program.

Effective January 1, 2018, the capitation rates shall be compliant with State Plan Amendment 18-005.

[County] – [Plan Code] – [HCP Number]

Commencing [DATE]		Full Duals	Non-Duals
Groups	Aid Codes	Rate	Rate
Family	01, 02, 0A, 3E, 3L, 3M, 3N, 3U, 3W, M3		
SPD	20, 23, 24, 26, 27, 36, 60, 63, 64, 66, 67, 2E, 2H, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 10, 13, 14, 16, 17, 1E, 1H		
Adult	53, 81		
Adult Expansion	M1, 7U, L1, L6		

Exhibit E, Attachment 1
Definitions

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms shall govern the construction of this Contract:

Action means a termination, suspension, or reduction (which includes denial of a service based on OGC interpretation of 42 CFR 431) of Medicaid eligibility or covered services. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

Actual Non-Service Expenditures means Contractor's actual amounts incurred for non-service expenditures, including both administrative and care management costs, for Full Benefit Dual Eligible Members and excludes costs incurred by Contractor prior to the start of this Risk Corridor. Any reinsurance costs reflected will be net reinsurance costs.

Actual Service Expenditures means Contractor's actual amount paid for providing services to Full Benefit Dual Eligible Members priced at Contractor fee level, and shall comprise of all provider payments for services to this population, including risk-sharing arrangements or sub-capitation payments.

Adjusted Non-Service Expenditures means Contractor's Actual Non-Service Expenditures, adjusted to reflect the exclusion of costs greater than 125 percent of the non-medical cost per Member per month across all participating Contractors and including any consideration given to Contractor for any significant, non-typical membership mixes that may cause this exclusion to come into effect as well as the exclusion of reinsurance costs which is the net of reinsurance premiums; and adjustments resulting from DHCS' review of Contractor's non-service expenditures to address any inappropriate or excessive non-service expenditures, including executive compensation and stop loss expenditures.

Adjusted Service Expenditures means Contractor's Actual Service Expenditures adjusted to reflect the following reductions from any recoveries of other payers outside of claims adjudication, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Member contributions to care; and adjustments resulting from DHCS' review of Contractor reimbursement methodologies and levels to address any excessive pricing.

Exhibit E, Attachment 1
Definitions

~~1.~~ **Administrative Costs** means only those costs that arise out of the operation of the plan excluding direct and overhead costs incurred in the furnishing of health care services, which would ordinarily be incurred in the provision of these services whether or not through a plan.

Adult Day Health Care (ADHC) means an organized day program of therapeutic, social and health activities and services provided to persons 55 years or older or other adults with functional impairments, either physical or mental, for the purpose of restoring or maintaining optimal capacity for self-care as set forth in California Code of Regulations, title 22, Section 78007.

Adult Day Health Care (ADHC) Center means a facility licensed to provide adult day health care, or a distinct portion of a licensed health facility in which such care is provided in a specialized unit, under a special permit issued by the Department of Public Health pursuant to California Code of Regulations, title 22, section 54105.

Advance Directive: a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

~~2.~~ **Affiliate** means an organization or person that directly or indirectly through one or more intermediaries' controls or is controlled by or is under control with Contractor and that provides services to or receives services from, Contractor.

~~3. **AIDS Beneficiary** means a Member for whom a Diagnosis of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) has been made by a treating Physician based on the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention.~~

~~4.~~ **Allied Health Personnel** means specially trained, licensed or credentialed health workers other than Physicians, podiatrists, and Nurses.

Allowed Medical Expenses means Contractor's actual expenses incurred and accounted for in accordance with Generally Accepted Accounting Principles (GAAP) for Covered Services delivered to Members during each period, including expenses incurred for utilization management and quality assurance activities, shared risk pools, incentive payments to providers,

and excluding administrative costs as defined in Title 28 CCR Section 1300.78.

A. For the MLR calculation, designated medical expense amounts included in the capitation rates that Contractor is required to pay providers, such as for intergovernmental transfers and Hospital Quality Assurance Fees, are excluded.

B. Global sub-capitation payments made by Contractor, where entire medical expenses are shifted to another entity, possibly net of utilization management or quality assurance, shall not exceed 95 percent, unless otherwise agreed by DHCS of the net capitation payments for consideration within Allowed Medical Expenses.

C. Payments by Contractor to related party providers shall not exceed the rate paid by Contractor for the same services to unrelated parties within the same county. Related parties are defined by GAAP.

~~5.~~ **Ambulatory Care** means the type of health services that are provided on an outpatient basis.

~~6.~~ **Appeal** means a Member's action taken with respect to the PACE organization's noncoverage of, **modification of,** or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.

~~7.~~ **Applicant** means any Member, as defined in this Attachment, provision 59, who has applied for Membership in Contractor's plan.

~~8.~~ **At-Risk Service** means any identified Covered Service, as defined in this Attachment, provision 26A which Contractor agrees to accept responsibility to provide or arrange for in exchange for the Capitation payment.

~~9~~. **Beneficiary Identification Card (BIC)** means a permanent plastic card issued by the State to Medi-Cal recipients of entitlement programs which is used by Contractors to verify Medi-Cal eligibility.

Capitated Revenues means the amount of the PACE Capitation payments/revenues paid to Contractor by DHCS for all services provided to participants under this Contract.

~~10.~~ **Capitated Service** means any Medi-Cal Covered Service for which Contractor receives Capitation payment.

Exhibit E, Attachment 1
Definitions

~~11.~~ **Capitation** means the monthly payment to Contractor for **Medi-Cal** services covered by the Contract.

~~12.~~ **Capitation Rate** means the amount paid per Member per month for services to be provided at-risk.

~~13.~~ **Case Management** means responsibility for referral, consultation, ordering therapy, admission to hospitals, follow-up care, and prepayment approval of referred services. It includes responsibility for location, coordination, and monitoring all medical care on behalf of a Member.

~~14.~~ **Catastrophic Coverage Limitation** means the date beyond which Contractor is not at risk, as determined by the Director, to provide or make reimbursement for illness of or injury to beneficiaries which results from or is greatly aggravated by a catastrophic occurrence or disaster, including, but not limited to, an act of war, declared or undeclared, and which occurs subsequent to Enrollment.

~~15.~~ **Center** means a Facility operated by a PACE Organization where Primary Care is furnished to plan Members.

~~16.~~ **Claims and Eligibility Real-Time System (CERTS)** means the mechanism for verifying a recipient's Medi-Cal or County Medical Services Program (CMSP) eligibility by computer.

Complete Claim means a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

Cold-Call Marketing means any unsolicited personal contact by the Contractor with a potential Member for the purpose of marketing (as identified within the definition of Marketing).

~~17.~~ **Confidential Information** means specific facts or documents identified as "confidential" by any law, regulations or contractual language.

~~18.~~ **Contract** means this written agreement between DHCS and Contractor.

~~19.~~ **Contracting Officer** means the single administrator of this Contract appointed by the Director DHCS. On behalf of DHCS, the Contracting Officer shall make all determinations and take all action as are appropriate to implement this Contract, subject to the limitations of the Contract.

Exhibit E, Attachment 1
Definitions

~~20.~~ **Contracting Providers** means a Physician, Nurse, technician, teacher, researcher, hospital, home health agency, nursing home or any other individual or institution that contracts with a Contractor to provide medical services to **Contractor's PACE plan** Members.

~~21.~~ **Contractor's Representative** means the single administrator who is authorized to bind Contractor on all matters related to this contract and take all actions as are necessary to implement Contractor's obligations, subject to the limitations of the Contract.

~~22.~~ **Contractor** means an entity doing business as [PACE Plan Name].

~~23.~~ **Corrective Actions** means specific identifiable activities or undertakings of Contractor which address program deficiencies or problems identified by formal audits or **by CMS or** DHCS monitoring **or oversight** activities.

~~24.~~ **Cost Avoid** means Contractor bills or requires a provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to Contractor paying the provider for the services rendered.

~~25~~. **County Department** means the County Department of Social Services (DSS) or other county agency responsible for determining the **applicant or member's** initial and continued eligibility for the Medi-Cal program.

~~26.~~ **Covered Services** means those items and services provided by Contractor under the provisions of ~~W&I~~ **Welfare and Institutions** Code, ~~S~~**s**ection 14132 **and the California State Plan,** except those services specifically excluded under this paragraph, **state law, or the California State Plan**.

A. Covered Services include, but are not limited to:

1) Acute inpatient care, including the following:

a. Ambulance

b. Emergency room care and treatment room services

c. Semi-private room and board

d. General medical and nursing services

e. Medical surgical/intensive care/coronary care unit

Exhibit E, Attachment 1
Definitions

f. Laboratory tests, x-rays and other diagnostic procedures

g. Drugs and biologicals

h. Blood and blood derivatives

i. Surgical care, including the use of anesthesia

j. Use of oxygen

k. Physical, occupational, respiratory therapies, and speech language pathology services

l. Social Services

m. Inpatient Mental Health

2) Interdisciplinary Team Assessment and Treatment Planning

3) Adult Day Health Center and Clinic Services as set forth in **California Code of Regulations,** ~~T~~**t**itle 22, ~~CCR~~, ~~S~~**s**ections 54309 **through** 54323 including, but not limited to, the following:

a. Primary Care, including Physician and nursing services

b. Social work services

c. Restorative therapies, including physical therapy and occupational therapy

d. Personal care and supportive services

e. Nutritional counseling

f. Recreational therapy

g. Meals

h. Transportation

4) Home Care Services, including ~~the following:~~

~~a.~~ Home Health Services

Exhibit E, Attachment 1
Definitions

~~b. In-Home Supportive Services~~

5) Outpatient mental health services

6) Drugs and biologicals

7) Laboratory tests, x-rays, and other diagnostic procedures

8) Medical specialty services including, but not limited to the following:

a. Anesthesiology

b. Audiology

c. Cardiology

d. Dentistry

e. Dermatology

f. Gastroenterology

g. Gynecology

h. Internal medicine

i. Nephrology

j. Neurosurgery

k. Oncology

l. Ophthalmology

m. Oral surgery

n. Orthopedic surgery

o. Otorhinolaryngology

p. Plastic surgery

Exhibit E, Attachment 1
Definitions

q. Pharmacy consulting services

r. Podiatry

s. Psychiatry

t. Pulmonary disease

u. Radiology

v. Rheumatology

w. General surgery

x. Thoracic and vascular surgery

y. Urology

9) Nursing Facility care, including the following:

a. Semi-Private room and board

b. Physician and skilled nursing services

c. Custodial care

d. Personal care and assistance

e. Drugs and biologicals

f. Physical, occupational, recreational therapies, and speech language pathology, if necessary

g. Social services

h. Medical supplies and appliances

10) Other services determined necessary by the IDT to improve and maintain the ~~participant's~~ **member's** overall health status

11) Prosthetics, orthotics, durable medical equipment, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items~~.~~

Back to Agenda Back to Item

Exhibit E, Attachment 1
Definitions

12) Major Organ Transplants

B. Covered Services do not include:

1) Any service that has not been authorized by the IDT, even if it is a required service, unless it is an emergency service;

2) Services rendered in a non-emergency setting or for a non-emergency reason without Prior Authorization;

3) Prescription and over-the-counter drugs not prescribed by Contractor's Physician;

4) In an inpatient Facility, private room and private duty nursing services (unless medically necessary), and nonmedical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the IDT as part of the Member's plan of care);

5) Cosmetic surgery, ~~unless~~ **which does not include surgery that is** required for improved functioning or a malformed part of the body resulting from an accidental injury or for reconstruction following a mastectomy;

6) Experimental ~~drugs and~~ medical, surgical or other health procedures;

7) Care in a government hospital (VA, federal/state hospital);

8) Any services rendered outside of the United States, except in accordance with 42 CFR, ~~Sections~~ 424.122 and 424.124**, or as permitted under the Medi-Cal approved Medicaid Plan**;

~~27.~~ **Credentialing** means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.

~~28. **Days** shall mean calendar days, unless otherwise specified in Contract.~~

~~29.~~ **Department of Health and Human Services (DHHS)** means the federal agency responsible for management of the Medicaid program.

Exhibit E, Attachment 1
Definitions

~~30.~~ **Department of Health Care Services (DHCS)** means the single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program~~, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs~~.

Department of Managed Health Care (DMHC) means the State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.

~~31.~~ **Diagnosis of AIDS** means a clinical diagnosis of AIDS that meets the most recent communicable disease surveillance case definition of AIDS established by the federal Centers for Disease Control and Prevention (CDC), ~~United States Department of Health and Human Services~~ ~~(~~**DHHS**~~)~~, and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements, in effect for the month in which the clinical diagnosis is made.

~~32.~~ **Dietitian/Nutritionist** means a person who is registered or eligible for registration as a Registered Dietitian by the Commission on Dietetic Registration (Bus~~.iness and~~ **&** Prof~~.essions~~ Code, **c**~~C~~hapter 5.65, **s**~~S~~ections 2585 and 2586).

~~33.~~ **Director** means the Director of the State of California Department of Health Care Services

~~34.~~ **Disenrollment** means the Department-approved discontinuance of a Member's entitlement to receive Covered Services under the terms of this Contract and the deletion from the approved list of Members furnished by the Department to Contractor.

Discharge Planning means planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

Disproportionate Share Hospital (DSH) means a health facility licensed pursuant to Health and Safety Code, chapter 2, division 2, to provide acute inpatient hospital services, which is eligible to receive payment adjustments from the State pursuant to Welfare and Institutions Code, section 14105.98.

Exhibit E, Attachment 1
Definitions

Dual-Eligible Beneficiary means an individual who is enrolled for benefits under Part A of Title 42 of the United States Code (commencing with Section 1395c) and Part B of Title 42 of the United States Code (commencing with Section 1395j) and is also eligible for medical assistance under the Medi-Cal State Plan.

~~35.~~ **Eligible Beneficiary** means any Medi-Cal beneficiary who is residing in Contractor's Service Area, 55 years of age or older, determined by DHCS as ~~eligible for~~ **requiring** nursing home level of care, and **is** able to live in a community setting without jeopardizing his **or** ~~(~~her~~)~~ health or safety, **with one of the following aid codes:**~~.~~

Family aid codes 01, 02, 0A, 3E, 3L, 3M, 3N, 3U, 3W, M3
SPD aid codes 20, 23, 24, 26, 27, 36, 60, 63, 64, 66, 67, 2E, 2H, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 10, 13, 14, 16, 17, 1E, 1H
Adult aid codes 53, 81
Adult Expansion aid codes M1, 7U, L1, L6

~~36.~~ **Emergency Management Plan** means a strategy developed with steps for response and recovery from an unplanned event that could cause death or significant injury to employees, eligible beneficiaries or the public; or that can shut down business, disrupt operations, stop claims payment, cause physical or environmental damage or threaten the facility's financial standing or public image. Numerous events can be "emergencies" including: fire, hazardous material incident, flood or flash flood, hurricane, tornado, winter storm, earthquake, communications failure, radiological accident, civil disturbance, loss of a key supplier or customer or an explosion.

~~37. **Emergency Medical Condition** means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain), such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:~~

~~A. Placing the health of the individual in serious jeopardy,~~

~~B. Serious impairment to bodily function, or~~

~~C. Serious dysfunction of any bodily organ or part.~~

~~38. **Emergency Services** means those health services needed to evaluate or stabilize an Emergency Medical Condition.~~

Exhibit E, Attachment 1
Definitions

~~39.~~ **Encounter** means any single medically related service rendered by (a) medical provider(s) to a Member enrolled in the plan during the date of service. It includes, but is not limited to, all services for which Contractor incurred any financial liability.

Encounter Data means the information that described health care interaction between Members and providers relating to the receipt of any item(s) or service(s) by a Member under this contract and subject to the standards of 42 CFR 438.242 and 438.818.

~~40.~~ **Enrollment** means the process by which an Eligible Beneficiary becomes a Member of Contractor's plan~~, in accordance with the provisions of Title 22, CCR, Section 53420~~.

41. **Enrollment Agreement** means a Contract between Contractor and Member which establishes the terms and conditions for Enrollment.

~~42.~~ **Facility** means any premise that is:

A. Owned, leased, used or operated directly or indirectly by or for Contractor or its affiliates for purposes related to this Contract**;** or

B. Maintained by a provider to provide services on behalf of Contractor.

~~43.~~ **Federal Financial Participation** means federal expenditures provided to match proper State expenditures made under approved State Medicaid plans.

Federally Qualified Health Center (FQHC) means an entity defined in Section 1905 of the Social Security Act (42 U.S.C. § 1396d(l)(2)(B)).

Fee-For-Service (FFS) means a method of payment based upon per unit or per procedure billing for services rendered to an Eligible Beneficiary.

Fee-For-Service Medi-Cal means the component of the Medi-Cal Program which Medi-Cal providers are paid directly by the State.

~~44.~~ **Financial Performance Guarantee** means cash or cash equivalents which are immediately redeemable upon demand by DHCS, in an amount determined by DHCS, which shall not be less than one full month's Capitation.

~~45.~~ **Financial Statements** means the Financial Statements as defined by Generally Accepted Accounting Principles (GAAP) which include a Balance Sheet, Income Statement, Statement of Cash Flows, Statement of Equity and accompanying

footnotes prepared in accordance with GAAP. All documents are prepared in accordance with GAAP.

~~46.~~ **Fiscal Year (FY)** means any 12-month period for which annual accounts are kept. The State Fiscal Year is July 1 through June 30, **and** the federal Fiscal Year is October 1 through September 30.

General and Administrative Expenses means expenses as defined in California Code of Regulations, title 28, section 1300.78. These expenses are not part of Allowed Medical Expenses, but are part of Net Capitation Payments.

~~47.~~ **Grievance** means a complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.

Health Maintenance Organization (HMO) means an organization that is not a federally qualified HMO, but meets the State Plan's definition of an HMO including the requirements under section 1903(m)(2)(A)(i-vii) of the Social Security Act. An Organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined periodic fixed prepayment.

~~48.~~ **Health Plan Employer Data and Information Set (HEDIS)** means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

HEDIS® Compliance Audit means an audit process that uses specific standards and guidelines for assessing the collection, storage, analysis, and reporting of HEDIS® measures. This audit process is designed to ensure accurate HEDIS® reporting.

~~49. **Health Promotion and Disease Prevention Care** means those medical examinations, procedures, and/or tests provided by Contractor with the objective of promoting positive and optimum health, to prevent departure from baseline health, and to cure or prevent disabling illness after the onset of certain diseases. The protocols for Health Promotion and Disease Prevention Care provided by Contractor are deemed appropriate for a frail population when approved by the governing body, the Medical Advisory Committee of Contractor and the DHCS.~~

Indian Health Programs means Facilities operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care

Exhibit E, Attachment 1
Definitions

Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area (California Code of Regulations, title 22, section 55000).

~~50.~~ **Interdisciplinary Team** means a team composed of ~~at least the following members to comprehensively assess and meet the individual needs of each Member~~ **members qualified to fill, at minimum, the following roles, in accordance with 42 CFR 460.102. One individual may fill two separate roles on the interdisciplinary team where the individual meets applicable state licensure requirements and is qualified to fill the two roles and able to provide appropriate care to meet the needs of members:**

A. Primary Care ~~Physician~~ **Provider;**

Primary medical care must be furnished to a member by any of the following:

1) A primary care physician.

2) A community-based physician.

3) A physician assistant who is licensed in the State and practices within his or her scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority.

4) A nurse practitioner who is licensed in the State and practices within his or her scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority.

B. Registered Nurse**;**

C. **Master's –level** Social Worker**;**

D. Physical Therapist**;**

E. Occupational Therapist**;**

F. Recreational Therapist or Activity Coordinator**;**

G. Dietician**;**

Back to Agenda Back to Item

Exhibit E, Attachment 1
Definitions

H. PACE Center Manager**;**

I. Home Care Coordinator**;**

J. Personal Care Attendant or his or her representative**; and**

K. Driver or his or her representative

Integrated Systems of Care Division (ISCD) means the division within DHCS that manages and monitors the Contract.

~~51.~~ **Intermediate Care Facility (ICF)** means a Facility ~~which~~ **that** is licensed as an ICF by DHCS or a hospital or Skilled Nursing Facility which meets the standards specified in **California Code of Regulations,** ~~T~~**t**itle 22, ~~S~~**s**ection 51212 and has been certified by DHCS for participation in the Medi-Cal program.

Joint Commission on the Accreditation of Health Care Organizations (JCAHO) means the organization composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association. JCAHO provides health care accreditation and related services that support performance improvement in health care organizations.

Knox-Keene Health Care Service Plan Act of 1975 means the law that regulates HMOs and is administrated by the DMHC, commencing with section 1340, Health & Safety Code.

~~52. **Long-Term Care Division (LTCD)** means the division within DHCS that manages and monitors the Contract.~~

~~53.~~ **Marketing** means any activity conducted **by or** on behalf of Contractor where information regarding the services offered by Contractor is disseminated in order to persuade Eligible Beneficiaries to enroll. **Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of Contractor.**

Marketing Materials means materials produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to potential enrollees.

~~54.~~ **Marketing Representative** means a person who is engaged in Marketing activities on behalf of Contractor ~~through direct employment by Contractor~~.

Exhibit E, Attachment 1
Definitions

~~55.~~ **Medi-Cal Eligibility Data System (MEDS)** means the automated eligibility information processing system operated by the State which provides on-line access for recipient information, update of recipient eligibility data and on-line printing of immediate need Beneficiary Identification Cards.

Medical Expenses means Contractor's actual expenses incurred and accounted for in accordance with the Generally Accepted Accounting Principles for Covered Services delivered to Members during each period. This includes expenses incurred for provider payment incentive programs, medical management, utilization management and quality assurance activities, but excludes administrative costs as defined in California Code of Regulations title 28, section 1300.78 as well as pass-through items such as intergovernmental transfers, Hospital Quality Assurance Fees, and MCO/Sales taxes.

Medical Loss Ratio (MLR) means the Allowed Medical Expenses for the covered services provided to enrollees under the Contract divided by the amount of Medi-Cal managed care Net Capitation Payments or revenues recorded by Contractor, by county. The MLR will be measured by the same county that was used in the development of the capitation rates paid to the Contractor, under this Contract. The calculation excludes both the portion of Contractor's capitation revenues and associated expenses for items such as intergovernmental transfers, Hospital Quality Assurance Fees, MCO/Sales taxes, and the Health Insurance Providers Fee (HIPF).

If a Staff Model Contractor does not account for Medical Expenses specifically by line of business and uses an allocation methodology, the MLR shall be the average MLR of all other Medi-Cal managed care contractors operating within the county in which Contractor operates. In such cases, Staff Model Contractor's MLR shall be excluded from the average MLR.

~~56.~~ **Medi-Cal Managed Care Division** means the division within the DHCS that has the responsibility, along with ~~the Long-Term Care Division~~ **ISCD**, ~~of~~ **for** monitoring managed care Contracts.

~~57.~~ **Medical Records** means written documentary evidence of treatments rendered to plan Members.

~~58.~~ **Medically Necessary** or **Medical Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability or to

alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

~~59.~~ **Member** means any Eligible Medi-Cal Beneficiary who has enrolled in Contractor's plan in accordance with the provisions of **California Code of Regulations** ~~T~~**t**itle 22, ~~CCR,~~ ~~S~~**s**ection 53420. For the purposes of this Contract, "Enrollee" shall have the same meaning as "Member**"**.

~~60. **This provision intentionally left blank.**~~

National Committee for Quality Assurance (NCQA) is a non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

NCQA Licensed Audit Organization is an entity licensed to provide auditors certified to conduct HEDIS Compliance Audits.

Net Capitation Payments means Contractor's capitation revenues less designated amounts included in capitation rates that Contractor is required to pay to providers, such as for intergovernmental transfers and HQAFs, and the State, such as for Contractor premium/Sales taxes, Hospital Quality Assurance Fees, and the Health Insurance Providers Fee (HIPF). Net Capitation Payments shall exclude retroactive adjustments relating to the prior service period(s) and shall include amounts accrued/recognized for the service period in accordance with Generally Accepted Accounting Principles (GAAP).

~~61.~~ **Non-Emergency Medical Transportation** means ~~inclusion of services outlined~~ **ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per** ~~in~~ **California Code of Regulations** ~~T~~**t**itle 22, ~~CCR,~~ ~~S~~ **s**ections **51323**, 51231.1 and 51231.2 rendered by licensed providers.

~~62.~~ **Non-Medical Transportation** means transportation of Members to medical services by passenger car, taxicabs or other forms of public or private conveyances provided by persons not registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm or otherwise incapacitated Members by ambulances, litter vans or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances or regulations.

Exhibit E, Attachment 1
Definitions

~~63.~~ **Non-Physician Medical Practitioners (Mid-Level Practitioner)** means a nurse practitioner or ~~p~~**P**hysician assistant authorized to provide Primary Care under Physician supervision.

Not Reported means: 1) Contractor calculated the measure but the result was materially biased; 2) Contractor did not calculate the measure even though a population existed for which the measure could have been calculated; and/or, 3) Contractor calculated the measure but chose not to report the rate.

~~64.~~ **Nurse** means a person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN).

Nursing Facility Level of Care means the Level of Care meeting criteria established in the department's approved Medi-Cal Manual of Criteria for Medi-Cal Authorization that includes California Code of Regulations, title 22, sections 51334 and 51335.

~~65.~~ **Other Healthcare Coverage Sources** (OHCS) means the responsibility of an individual or entity, other than Contractor or the Member, for the payment of the reasonable value of all or part of the healthcare benefits provided to a Member. Such OHCS may originate under any other State, federal or local medical care program or under other contractual or legal entitlement, including, but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding Tort Liability.

~~66.~~ **Outpatient Care** means treatment provided to a Member who is not confined in a health care Facility. ~~Outpatient care is associated with treatment in a hospital that does not necessitate an overnight stay, e.g., emergency treatment.~~

Outpatient Mental Health Services means outpatient services that Contractor will provide for Members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate a mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies, and supplements.

~~67.~~ **PACE** stands for the Program of All-Inclusive Care for the Elderly.

PACE Center means the location designated by Contractor at which Members shall receive PCP services.

Exhibit E, Attachment 1
Definitions

~~68.~~ **PACE Organization** means an organization which meets the requirements of 42 CFR Section 460.60**, and all other state and federal statutes and regulations applicable to PACE plans,** and has signed a PACE Program agreement with ~~the Centers for Medicare and Medicaid Services (~~CMS~~)~~ and ~~the Department of Health Care Services~~ **DHCS**.

Person-Centered Planning means an ongoing process designed to develop an individualized care plan specific to each person's abilities and preferences.

~~69.~~ **Physician** means a person duly licensed as a Physician by the Medical Board of California.

~~70.~~ **Physician Incentive Plan** means any compensation arrangement between Contractor and a Physician or a Physician group that may not directly or indirectly have the effect of reducing or limiting services provided to Members under this Contract.

~~71.~~ **Policy Letter** means a document that has been dated, numbered, and issued by the ~~Medi-Cal Managed Care Division~~ **MMCD** or ~~the~~ ~~Long-Term Care Division~~ **ISCD** that clarifies regulatory or contractual requirements.

~~72.~~ **Policy Statement** means a detailed goal statement in which Contractor commits to meet all aspects of this Contract.

~~73.~~ **Post-Payment Recovery** means Contractor pays the provider for the services rendered and then uses all reasonable efforts to recover the cost of the services from all liable third parties.

Post Stabilization Care means services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized. They are not emergency services, which POs are obligated to cover. Rather, they are non-emergency services that the PO should approve before they are provided outside the service area.

~~74.~~ **Preventive Care** means health care designed to prevent disease and/or its consequences. ~~There are three levels of Preventive Care; primary, such as immunizations, aimed at preventing disease; secondary, such as disease screening programs, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred.~~

Exhibit E, Attachment 1
Definitions

~~75.~~ **Primary Care** means a basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasizes caring for the Member's general health needs as opposed to specialists focusing on specific needs.

Primary Care Dentist means a dentist responsible for supervising, coordinating, and providing dental care to Member.

~~76.~~ **Primary Care Physician (PCP)** means a Physician responsible for supervising, coordinating, and providing initial and Primary Care to patients **and serves as the medical home for Members**.~~; for initiating referrals for specialist care; and for working in conjunction with an IDT to ensure continuity of patient care and effective Case Management. A Primary Care Physician~~ **The** ~~(~~PCP~~)~~ is a ~~Physician~~ **general practitioner, internist, pediatrician, family practitioner, or** who ~~has limited his/her practice of medicine to general~~ obstetrician/gynecologist **(OB/GYN).**

~~77.~~ **Primary Care Provider (PC)** means a person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a ~~Primary Care Physician~~ ~~(~~**PCP**~~)~~ or Non-Physician Medical Practitioner.

~~78.~~ **Prior Authorization** means ~~the~~ **a formal** process ~~by which Contractors approve, usually in advance of the rendering, requested medical services. This is part of the Utilization Management System~~ **requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a member to receive a specific service or procedure.**

Provider Grievance means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration or appeal made by a provider. DHCS considers complaints and appeals the same as a grievance.

Prior Authorization Request means a method by which practitioners seek approval from Contractor to render medical services. Contractor's IDT is responsible for granting approval to providing specific, non-emergency medical services in advance of rendering such services.

~~79.~~ **Procedures** means a detailed description of how Contractor and its designees ~~shall~~ **will** achieve the goal. It ~~shall~~ **will** contain details of systems, processes, and

lines of communication integral to achieving the policy **as stated in Contractor's Policy and Procedures manuals.**

~~80.~~ **Program Director** means a person responsible for oversight and administration of the entity as specified by 42 CFR Section 460.60(b).

~~81.~~ **Protocols** means a written plan of delivery of services and must identify how the services are delivered for standard, consistent care to Members.

~~82.~~ **Provider of Services** means any individual, partnership, clinic, group, association, corporation, institution or public agency meeting applicable standards for participation with the Medi-Cal program as defined in **California Code of Regulations** ~~T~~**t**itle 22, ~~CCR~~, ~~Division 3, Subdivision 1, Chapter 3, Article 3 (commencing with S~~**s**ection 51200 **et seq.**~~)~~.

~~83.~~ **Provider Appeal** means an Appeal concerning the authorization or denial of a service**,**~~;~~ denial, deferral or modification of a Prior Authorization request on behalf of a Member or the processing of a payment or non-payment of a claim by the Contractor.

~~84.~~ **Quality Assurance (QA)** means a formal set of activities to assure the quality of clinical and non-clinical services provided. Quality Assurance includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process. Comprehensive Quality Assurance includes mechanisms to assess and assure the quality of both health services and administrative and support services.

~~85.~~ **Quality Improvement (QI)** means the result of an effective Quality Improvement **System** ~~program which objectively and systematically monitors and evaluates the quality and appropriateness of care and services to Members through Quality of Care studies and other health related activities.~~

~~86.~~ **Quality Improvement System (QIS)** means ~~consisting of~~ systematic activities to monitor and evaluate the medical care delivered to Members according to the standards set forth in regulations and contract language. **Contractor** ~~The plan~~ must have processes in place~~, which~~ **that** measure the effectiveness of care, identify~~y~~**ies** problems, and implement**s** improvement on a continuing basis. ~~The QIS is referred to as Quality Assessment and Performance Improvement (QAPI) by the Centers for Medicare/Medicaid Services (CMS).~~

~~87.~~ **Quality of Care** means the degree to which health services for individuals and populations increase**s** the likelihood of desired health outcomes and are consistent with current professional knowledge.

Exhibit E, Attachment 1
Definitions

Quality Incidents means an unexpected occurrence that caused a Member death or serious physical or psychological injury that included permanent loss of function. Included in this definition are any medical equipment failures that could have caused a death and all attempted suicides.

~~88.~~ **Quality Indicators** means measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcome of care delivered in that clinical area.

~~89.~~ **Reinsurance** means coverage secured by Contractor, which limits the amount of risk or liability assumed under this Contract.

Rural Health Clinic (RHC) means an entity defined in California Code of Regulations title 22, section 51115.5.

Safety-Net Provider means any provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the provider. Examples of safety-net providers include FQHCs; governmentally operated health systems; community health centers; Rural and Indian Health Programs; disproportionate share hospitals; and public, university, rural, and children's hospitals.

~~90.~~ **Seniors and Persons with Disabilities (SPD)** means Medi-Cal beneficiaries who fall under specific Aged and Disabled aid codes as defined by the department (See Eligible Beneficiary).

Sensitive Services means those services related to:

A. Sexually transmitted diseases (STDs)

B. HIV testing

Screening, Brief Intervention, and Referral to Treatment (SBIRT) means services provided by a PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol.

~~91.~~ ~~**Sentinel Event** means an unexpected occurrence that caused a Member death or serious physical or psychological injury that included permanent loss of~~

~~function. Included in this definition are any medical equipment failures that could have caused a death and all attempted suicides.~~

~~92.~~ **Service Area** means ~~geographical area comprised of those areas designated by the U.S Postal Service ZIP Codes that have been proposed by Contractor and approved in writing by the Department, after careful evaluation to ensure adequate access to health care services by plan Members who reside therein~~ **the county or counties in which Contractor is approved to operate under the terms of this Contract. A Service Area may have designated ZIP codes (under the U.S. Postal Service) within a county that are approved by DHCS to operate under the terms of this Contract.**

~~93.~~ **Service Location** means any location at which a Member obtains any health care services provided by Contractor under the terms of this Contract.

~~94.~~ ~~**Service Site** means the location designated by Contractor at which Members shall receive PCP services.~~

~~95.~~ **Skilled Nursing Facility (SNF)** means, as defined in **California Code of Regulations** ~~T~~**t**itle 22, ~~CCR, subdivision S~~**s**ection 51121(a), any institution, place, building or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home**,**" "convalescent hospital**,**" "nursing home**,**" or "nursing facility".

Specialty Mental Health Provider means a person or entity who is licensed, certified or otherwise recognized or authorized under State law governing the healing arts and who meets the standards for participation in the Medi-Cal program to provide Specialty Mental Health Services.

Specialty Mental Health Service means those services identified in 9 CCR section 1810.247, including but not limited to:

A. Rehabilitative Mental Health Services, including:

a. Mental health services;

b. Medication support services;

c. Day treatment intensive;

d. Day rehabilitation;

e. Crisis intervention;

f. Crisis stabilization;

g. Adult residential treatment services;

h. Crisis residential treatment services;

i. Psychiatric health facility services;

j. Psychiatric Inpatient Hospital Services;

k. Targeted Case Management;

l. Psychiatrist Services;

m. Psychologist Services;

n. EPSDT Supplemental Specialty Mental Health Services; and

o. Psychiatric Nursing Facility Services.

~~96.~~ **State** means the State of California.

~~97.~~ ~~**State Employee** includes, but is not limited to:~~

~~A. The Director of the Department of Health Care Services, and~~

~~B. The following appointive and civil services employees of the Department:~~

~~Chief Deputy Director~~

~~Deputy Director~~

~~Chief Counsel~~

~~Division Chiefs~~

~~Branch Chiefs~~

~~Section Chiefs; and or~~

~~Office, Unit, Bureau, Project and Program Chief or Managers~~

~~98.~~ **State Officer** means

A U.S. Senator or member of Congress representing California

The Governor

The Lieutenant Governor

The Secretary of State

The Controller

The Treasurer

The Attorney General

The State Superintendent of Public Instruction**; or**

A member of the Legislature~~; or~~

~~A secretary of a State Agency~~

Subacute Care means, as defined in California Code of Regulations, title 22 section 51124.5, a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a SNF.

~~99.~~ **Subcontract** means a written agreement entered into by Contractor with any of the following:

A. A provider of health care services who agrees to furnish Covered Services to Member~~s.~~**; and**

B. Any other organization or person(s) who agree(s) to perform any administrative function or service for Contractor specifically related to fulfilling Contractor's obligations to DHCS under the terms of this Contract.

~~100.~~ **Sub-Subcontractor** means any party to an agreement with a subcontractor descending from and subordinate to a Subcontract, which is entered into for the

purpose of providing any goods or services connected with the obligations under this Contract.

~~101. **Substantial Financial Interest** means the ownership of:~~

~~A. Common stock~~

~~B. Preferred stock~~

~~C. Warrants~~

~~D. Options~~

~~E. Loans~~

~~F. Partnership interests~~

~~G. Debt instruments~~

~~H. Any ownership interest which consists of, or is convertible to, equity investments in this Contractor or this Contractor's subcontractor(s) or sub-subcontractor(s). Ownership interest in terms of fair market value shall not be less than the greater of:~~
~~1) $1,000~~

~~2) Five percent or more of the total fair market value of all equity investments in the entity, including ownership interests convertible to such investments.~~

~~102.~~ **Supplemental Security Income (SSI)** means the program authorized by Title XVI of the Social Security Act **(42 U.S.C. §§ 1381-1383f)** for aged, blind, and disabled persons.

Telehealth means a method of delivering health care services by using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at a separate location from the health care provider. Telehealth facilitates the Member's self-management and caregiver support for the Member.

~~103.~~ **Third Party Tort Liability (TPTL)** means the responsibility of an individual or entity other than Contractor or the Member for the payment of claims for injuries or trauma sustained by a Member. This responsibility may be contractual, a legal

obligation or as a result of, or the fault or negligence of, third parties (e.g., auto accidents**,** ~~or~~ other personal injury casualty claims**,** or Workers' Compensation Appeals).

~~104.~~ **Unusual Incident or Injury** means one which threatens the welfare, safety or health of any Member, and which is not consistent with the Center's routine operation or Member care. Any incident that meets the ~~level one and level two~~ **quality incident** criteria established by the CMS HPMS reporting guidelines, regardless of where it occurred, must be reported.

~~105. **Unusual Occurrences, Fires, and Explosions** means occurrences such as epidemic outbreaks, poisonings, catastrophes or major accidents, and fires or explosions which occur in or on the premises and threaten the welfare, safety or health of Members, employees or visitors.~~

~~106.~~ **Unusual or Seldom-Used Health Care Services** means those services of which 12 or fewer transactions are performed by Contractor in any one year period.

~~107.~~ **Urgent Care** means on-site services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones). Off-site Urgent care, as defined by federal PACE regulation 42 CFR ~~Section~~ 460.100(e)(3), means the care provided to a PACE ~~participant~~ **member** who is out of the PACE Service Area, and who believes ~~their~~ **his or her** illness or injury is too severe to postpone treatment until they return to the Service Area, but their life or function is not in severe jeopardy. ~~For purposes of this provision, "Urgent Care" means "on-site Urgent Care."~~

Utilization means the rate patterns of service usage or types of service occurring within a specified time. Inpatient Utilization is generally expressed in rates per unit of population-at-risk for a given period; e.g., the number of hospital admissions per 1,000 persons enrolled in an HMO/per year.

~~108.~~ **Utilization Review** means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and Facilities.

Working day(s) means State calendar (State Appointment Calendar, Standard 101) working day(s).

Exhibit E, Attachment 2
Program Terms and Conditions

1. Governing Law

In addition to Exhibit C, provision 14~~.~~ ~~Governing Law~~, Contractor also agrees to the following:

A. If it is necessary to interpret this Contract, all applicable laws may be used as aids in interpreting the Contract. However, the parties agree that any such applicable laws shall not be interpreted to create Contractual obligations upon DHCS or Contractor, unless such applicable laws are expressly incorporated into this Contract in some section other than this provision, Governing Law ~~or the Contract is amended for conformity pursuant to this provision, paragraph B~~. Except for provision 16. Sanctions, **and provision 17. Liquidated Damages below** ~~of this Attachment~~, the parties agree that any remedies for DHCS' or Contractor's non-compliance with laws not expressly incorporated into this Contract or any covenants implied to be part of this Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. In the event any provision of this Contract is held invalid by a court, the remainder of this Contract shall not be affected. This Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Contract, both parties shall be deemed authors of this Contract.

~~B.~~ Any provision of this Contract which is in conflict with current or future applicable federal and ~~S~~**s**tate laws or regulations, ~~including but not limited to, 42 CFR Part 460 and Chapter 8.75 (commencing with section 14590) of Part 3 of Division 9 of the Welfare and Institutions Code,~~ is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties ~~hereto~~ even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Such amendment shall constitute grounds for termination of this Contract in accordance with the procedures and provisions of provision 14. paragraph C**.**, Termination – Contractor **below**. The parties shall be bound by the terms of the amendment until the effective date of the termination.

~~C~~**B**. All existing **final** Policy Letters issued by MMCD and ~~LTCD~~ **ISCD** applicable to PACE ~~are hereby incorporated into this Contract~~ **can be viewed at www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx** and shall be complied with by Contractor. All Policy Letters issued by MMCD and ~~LTCD~~ **ISCD**, applicable to PACE, subsequent to the effective

Back to Agenda Back to Item

date of this Contract shall provide clarification of Contractors obligations pursuant to this Contract, and may include instructions to Contractor regarding implementation of mandated obligations pursuant to changes in ~~S~~**s**tate or federal statutes or regulations, or pursuant to judicial interpretation.

In the event DHCS determines that there is an inconsistency between this Contract and a Policy Letter, the Contract shall prevail.

2. Entire Agreement

This written Contract and any amendments shall constitute the entire agreement between the parties. No oral representations shall be binding on either party unless such representations are reduced to writing and made an amendment to the Contract.

3. Amendment Process

In addition to Exhibit C, provision 2. ~~Amendment,~~ Contractor also agrees to the following:

Should either party, during the life of this Contract, desire a change in this Contract, that change shall be proposed in writing to the other party. The other party shall acknowledge receipt of the proposal within **ten** ~~(10)~~ **calendar** days of receipt of the proposal. The party proposing any such change shall have the right to withdraw the proposal **at** any time prior to acceptance or rejection by the other party. Any proposal shall set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract which would provide for the change. If the proposal is accepted, this Contract shall be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by DHHS, and the ~~S~~**s**tate Department of Finance, if necessary.

4. Change Requirements

A. General Provisions

The parties recognize that during the life of this Contract, the ~~Long-Term~~ **Integrated Systems of** Care Division and Medi-Cal Managed Care Program shall be a dynamic program requiring numerous changes to its operations and that the scope and complexity of changes shall vary widely over the life of the Contract. The parties agree that the development of a

system that has the capability to implement such changes in an orderly and timely manner is of considerable importance.

B. Contractor's Obligation to Implement

The Contractor will make changes mandated by DHCS. In the case of mandated changes in regulations, statutes, Federal guidelines, or judicial interpretation, DHCS may direct the Contractor to immediately begin implementation of any change by issuing a change order. If DHCS issues a change order, the Contractor will be obligated to implement the required changes while discussions relevant to any capitation rate adjustment, if applicable, are taking place. DHCS may, at any time, within the general scope of the Contract, by written notice, issue change orders to the Contract.

C. Moral or Religious Objections to Providing a Service

If the Contractor has a moral or religious objection to providing a service or referral for a service for which the Contractor is not responsible, during the term of this agreement, the Contractor shall notify the DHCS in writing providing sufficient detail to establish the moral or religious grounds for the objection.

5. Delegation ~~O~~o~~f~~f Authority

A. DHCS intends to implement this Contract through a single administrator, called the "Contracting Officer". The Director of DHCS shall appoint the Contracting Officer. The Contracting Officer, on behalf of DHCS, shall make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable federal and ~~S~~**s**tate laws and regulations. The Contracting Officer may delegate his/her authority to act to an authorized representative through written notice to Contractor.

B. Contractor shall designate a single administrator; hereafter called the "Contractor's Representative". Contractor's Representative, on behalf of Contractor, shall make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of the Contract, federal and ~~S~~**s**tate laws and regulations. Contractor's Representative may delegate his~~/~~ **or** her authority to act to an authorized representative through written notice to the Contracting Officer. Contractor's Representative shall be empowered to legally bind Contractor to all agreements reached with DHCS.

C. Contractor shall designate Contractor's Representative in writing **and shall notify the Contracting Officer**. ~~Such designation shall be submitted to the Contracting Officer~~, in accordance with Exhibit E, Attachment 2, provision 10. ~~Notices.~~

6. Authority of the State

~~A.~~ Sole authority to establish, define or determine the reasonableness, the necessity and level and scope of covered benefits under the PACE program administered in this Contract or coverage for such benefits or the eligibility of the beneficiaries or providers to participate in the PACE resides with DHCS.

~~B.~~ Sole authority to establish or interpret policy and its application related to the above areas ~~shall~~ **will** reside with DHCS.

~~C.~~ Contractor may not make any limitations, exclusions or changes in benefits or benefit coverage; any changes in definition or interpretation of benefits or any changes in the administration of the Contract related to the scope of benefits, allowable coverage for those benefits or eligibility of beneficiaries or providers to participate in the program, without the express, written direction or approval of the Contracting Officer.

7. Fulfillment of Obligations

No covenant, condition, duty, obligation or undertaking continued or made a part of this Contract shall be waived except by written agreement of the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation or undertaking to be kept, performed or discharged by the party to which the same may apply; and, until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party shall have the right to invoke any remedy available under this Contract or under law, notwithstanding such forbearance or indulgence.

8. Obtaining DHCS Approval

Contractor shall obtain written approval from DHCS in Exhibit E, Attachment 3, provision 5. ~~DHCS~~ Approval Process, prior to implementing, amending or using any of the following:

A. Providers of medical and dental covered services, except for providers of seldom used or unusual services as determined by the DHCS~~.~~**;**

B. Facilities and site expansions~~.~~**;**

C. Subcontracts and sub-subcontracts with providers or management services.**;**

D. Marketing activities.**;**

E. All Marketing materials, promotional materials, and public information releases relating to performance under this Contract, Enrollment Agreement: Terms and Conditions, and Member newsletters~~.~~**;**

F. Member Grievance procedure, including forms~~.~~**;**

G. Member Enrollment and Disenrollment procedures, including forms~~.~~**;**

H. Utilization control mechanism, including a description of the system to evaluate the quality of medical and dental care, conduct professional review activities, assess the performance of medical personnel, and monitor utilization and cost effectiveness~~.~~**;**

I. Any other protocol, policy or procedure requiring approval under this Contract~~.~~**; and**

J. Any deviation or change from the approved organizational structure.

9. Certifications

Contractor shall comply with certification requirements set forth in 42 CFR 438.604 and 42 CFR 438.606.

In addition to Exhibit C, provision 11~~. Certifications~~, Contractor also agrees to the following:

With respect to any report, invoice, record, papers, documents, books of account or other Contract required data submitted, pursuant to the requirements of this Contract, Contractor's Representative or his~~/~~ **or** her designee shall certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other Contract required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's

knowledge and belief, unless the requirement for such certification is expressly waived by DHCS in writing.

10. Notices

A. All Notices

All notices to be given under this Contract shall be in writing and shall be deemed to have been given when mailed~~,~~ to DHCS or Contractor at the following addresses:

Chief, ~~Long-Term Care Division~~
Integrated Systems of Care Division
Department of Health Care Services
1501 Capitol Avenue, MS ~~0018~~ **4502**
P.O. Box 9974**37**~~13~~
Sacramento, CA 95899-74**37**~~13~~

PACE Plan Name
dba: PACE Plan Name
Address
city, CA zip code

B. Notification of Intent Not to Renew

Should either party elect not to renew this Contract, this decision shall be conveyed in writing to the other party at least 90 days prior to the expiration of this Contract.

11. Term

The Contract shall become effective ~~[DATE]~~ **July 1, 2020**, and shall continue in full force and effect through ~~June 30, 2020~~ **December 31, 2024** subject to the provisions of Exhibit B, provision 1~~. Budget Contingency Clause~~**, CMS waiver approval**, and Exhibit D(F), provision 9. Federal Contract Funds.

12. Service Area

Contractor must serve a defined Service Area, identified by zip codes, approved by DHCS and CMS. Changes in the Service Area must be pre-approved by DHCS and CMS.

13. Contract Extension

DHCS shall have the exclusive option to extend the term of the Contract **for any Service Area** during the last 12 months of the Contract, as determined by the original expiration date or by a new expiration date if an extension option has been exercised. DHCS may invoke up to three separate extensions of up to

twelve (12) months each. Contractor ~~shall~~ **will** be given at least nine months prior written notice of DHCS' decision on whether or not it shall exercise this option to extend the Contract.

Contractor shall provide written notification to DHCS of its intent to accept or reject the extension within five ~~(5)~~ ~~S~~**s**tate working days of the receipt of the notice from DHCS.

14. Termination for Cause and Other Terminations

In addition to Exhibit C, provision 7~~. Termination for Cause~~, Contractor also agrees to the following:

A. Termination – State or Director

~~The State or Director may terminate this Contract for good cause shown at any time, subject to the provisions of W&I Code, Section 14304(a). Failure to comply with any of the terms of this Contract shall constitute cause for termination.~~

DHCS may terminate performance of work under this Contract in whole, or in part, whenever for any reason DHCS determines that the termination is in the best interest of the state.

DHCS shall notify Contractor of intent to terminate the contract at least six (6) months prior to the effective date of termination, except in cases described below in Paragraph B. Termination for Cause.

B. ~~Mandatory~~ Termination **for Cause**

1) DHCS shall terminate this Contract pursuant to the provisions of Welfare and Institutions Code, Section 14304(a) and Title 22 CCR Section 53873.

2) DHCS may terminate this Contract as stated in 42 USC Section 1395eee(e)(5)(B), and 42 CFR 460.50, including but not limited to:

a) Either DHCS determines there are significant deficiencies in the quality of care provided to enrolled members, or the Contractor has failed to comply substantially with conditions for a program or provider under this section or Section 1396u-4 of this title; and

b) Contractor has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, a plan to correct the deficiencies, or has failed to continue implementation of such a plan.

3) Notification shall be given at least six months prior to the effective date of termination, except in cases described below in Paragraph C.

~~1~~**4**) ~~The Director~~ **DHCS** shall terminate this Contract in the event that~~,~~**:** the Secretary, DHHS, determines that Contractor does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act. Notification ~~shall~~ **will** be given by DHCS at least 60 **calendar** days prior to the effective date of termination.

~~2~~**5**) In cases where the Director determines the health and welfare of Members is jeopardized by continuation of the Contract, the Contract shall be immediately terminated. Notification ~~shall~~ **will** state the effective date of, and the reason for, the termination.

Except for termination pursuant to Paragraph B., item 2) above, Contractor may dispute the termination decision through the dispute resolution process pursuant to Provision 18.~~Under these circumstances,~~ t**T**ermination **of this Contract** shall be effective on the last day of the month in which the Secretary or DHHS makes such determination, provided that DHCS provides Contractor with at least 60 **calendar** day~~'~~s**'** notice of the termination. The termination of this Contract shall be effective on the last day of the second full month ~~following~~ **from** the date of the notice of termination. Contractor agrees that 60 **calendar** days**'** notice is reasonable~~ under the terms of W&I Code, Section 14304~~. **Termination under this section does not relieve Contractor of its obligations under Provision 15 below. Phaseout Requirements shall be performed after Contract termination.**

C. Termination - Contractor

~~Contractor may terminate this Contract at any time by giving a minimum 90 day written notice to the Director to that effect, stating the reasons for the termination. The termination shall become effective on the last day of the second calendar month following the month in which notice of termination was given.~~

Grounds under which Contractor may terminate this Contract are limited to: (1) Unwillingness to accept the Capitation Rates determined by DHCS, or if DHCS decides to negotiate rates, failure to reach mutual agreement on rates; or (2) When a change in contractual obligations is created by a ~~S~~**s**tate or federal change in the Medi-Cal program or a lawsuit, that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the term of the Contract.

If Contractor invokes ground number 2, Contractor shall submit a detailed written financial analysis to DHCS supporting its conclusions that it cannot remain financially solvent. At the request of DHCS, Contractor shall submit or otherwise make conveniently available to DHCS, all of Contractor's financial work papers, financial reports, financial books and other records, bank statements, computer records, and any other information required by DHCS to evaluate Contractor's financial analysis.

For any Contract termination initiated by the Contractor, the Contractor must provide at least 90 days prior notice to CMS and DHCS, and at least 60 days prior notice to members.

DHCS and Contractor may negotiate an earlier termination date if Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this section. Termination under these circumstances shall not relieve Contractor from performing the Phaseout Requirements described in Provision 15 below.

D. Termination of Obligations

All obligations to provide Covered Services under this Contract or Contract extension shall automatically terminate on the effective date of any termination of this Contract pursuant to sections A, B, or C of this provision or upon expiration of the term of this Contract. Contractor shall be responsible for providing Covered Services to Members until the termination or expiration of this Contract and shall remain liable for the processing and payment of invoices and statements for Covered Services provided to Members prior to such expiration or termination. All eligible Medi-Cal beneficiaries shall be transferred to a fee-for-service or other

appropriate service status when this Contract has been terminated. **The Contractor shall provide assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.**

E. Notice to Members of Transfer of Care

Contractor shall develop and implement a detailed written plan for phase-down in the event of termination which includes the process for informing Members, the community, CMS and the ~~S~~**s**tate in writing about termination and transition procedures; and steps that shall be taken to help assist Members to obtain reinstatement of conventional Medi-Cal benefits, transition their care to other providers, and terminate Marketing and Enrollment activities. **At least 60 days prior to the proposed termination date of the Contract, Contractor must submit the detailed written plan for phase-down to DHCS for approval prior to implementation by the Contractor. Contractor must modify the detailed written plan for phase-down to obtain approval by DHCS.** ~~Contractor shall provide assistance to each Member in obtaining necessary transitional care through appropriate referrals and making the Member's medical records available to new providers.~~

15. ~~Turnover and~~ Phaseout Requirements

~~A plan that details the manner in which beneficiaries shall be shifted to other sources of care or be told of the cessation of the Contract.~~

A. ~~Turnover Requirements~~

~~Prior to the termination or expiration of this Contract and upon request by DHCS, Contractor shall assist DHCS in the orderly transfer of Member medical care. In doing this, Contractor shall make available to DHCS copies of Medical Records, Member files, and any other pertinent information; including information maintained by any subcontractor, necessary for efficient Case Management of Members, as determined by the Director. Costs of reproduction shall be borne by DHCS. In no circumstances shall a Medi-Cal Member be billed for this service.~~

DHCS shall withhold the lesser of an amount equal to 10% of the last month's Service Area capitation payment or one million dollars ($1,000,000) for each Service Area unless provided otherwise by the Financial Performance Guarantee, from the capitation payment of the

last month of the Operations Period for each Service Area until all activities required during the Phase-out Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

If all Phase-out activities for each Service Area are completed by the end of the Phase-out Period, the withhold will be paid to the Contractor. If the Contractor fails to meet any requirement(s) by the end of the Phaseout Period for each Service Area, DHCS will deduct the costs of the remaining activities from the wirthhold amount and continue to withhold payment until all activities are completed.

B. The objective of the Phase-out Period is to ensure that, at the termination of this Contract, the orderly transfer of necessary data and history records is made from the Contractor to DHCS or to a successor Contractor. The Contractor shall not provide services to Members during the Phase-out Period.

90 calendar days prior to termination or expiration of this Contract and through the Phase-out Period for each Service Area, the Contractor shall assist DHCS in the transition of Members and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, the Contractor will make available to DHCS copies of Medical Records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of Members, as determined by the Director. Under no circumstances will a Medi-Cal Member be billed for this activity.

BC. ~~Phase-out Requirements~~

Phase-out for this Contract shall consist of the processing, payment and monetary reconciliation(s) necessary regarding claims for payment for Covered Services.

Phase-out for the Contract shall consist of the ~~resolution~~ **completion** of all financial and reporting obligations of **the** Contractor. **The** Contractor ~~shall~~ **will** remain liable for the processing and payment of invoices and other claims for payment for Covered Services and other services provided to Members pursuant to this Contract prior to the expiration or termination. **The** Contractor ~~shall~~ **will** submit to DHCS all reports required in Exhibit A, Attachment 17~~, Reporting Requirements~~, for the period from the last submitted report through the expiration or termination date.

All data and information provided by Contractor ~~shall~~ **will** be accompanied by letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials supplied.

D. Phase-out Period will commence on the date the Operations Period of the Contract or Contract extension ends. Phase-out related activities are non-payable items.

16. Sanctions

If, as set forth in 42 CFR 460.42(b)(2), CMS denies medical assistance payment to DHCS for services furnished under this Contract based on the Contractor committing one or more violations specified in 42 CFR 460.40, then DHCS shall not be responsible for payment to Contractor in the amount of the CMS denial, and DHCS may recover any overpayment from Contractor based on the CMS payment denial either through an offset or direct reimbursement from Contractor.

Contractor is subject to sanctions and civil penalties taken pursuant to 42 CFR 460.4, 460.40 through 460.54, and 460.194 Welfare and Institutions Code Section 14304 and California Code of Regulations, title 22, section 53872; however, such sanctions and civil penalties may not exceed the amounts allowable pursuant to 42 CFR, 438.704. If required by DHCS, Contractor shall ensure subcontractors cease specified activities which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until DHCS determines that Contractor is again in compliance.

A. In the event DHCS finds Contractor non-compliant with any provisions of this Contract, applicable statutes or regulations**,** ~~or for good cause shown,~~ DHCS may impose sanctions provided in ~~W&I~~ **Welfare and Institutions** Code, ~~S~~**s**ection 14304 and ~~Title~~ **California Code of Regulations title** 22, ~~CCR,~~ ~~S~~**s**ection ~~53350~~ **53872 as modified for purposes of this Contract. California Code of Regulations, title 22, section 53872 is so modified as follows:** ~~Good cause includes, but is not limited to, three repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care identified in the medical audits conducted by DHCS.~~

1) Subsection (b)(1) is modified by replacing "Article 2" with "Article 6"

2) Subsection (b)(2) is modified by replacing "Article 3" with "Article 7"

Exhibit E, Attachment 2
Program Terms and Conditions

~~If required by DHCS, Contractor shall ensure subcontractors cease specified activities which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until DHCS determines that Contractor is again in compliance.~~

B. **The requirements of Exhibit A, Attachment 4, regarding QIS are all Contract provisions which are not specifically governed by Chapter 4.1 (commencing with Section 53800) of Division 3 of title 22, CCR. Therefore, sanctions for violations of the requirements of Exhibit A, Attachment 4, regarding QIS shall be governed by Subsection 53872 (b)(4).**

C. For purposes of Sanctions, good cause includes, but is not limited to, the following:

1) Three repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care identified in the medical audits conducted by DHCS.

2) In the case of Exhibit A, Attachment 4 Quality Improvement System, the Contractor consistently fails to achieve the minimum performance levels, or receives a "Not Reported" designation on an External Accountability Set measure, after implementation of Corrective Actions.

3) A substantial failure to provide medically necessary services required under this Contract or law to a Member.

4) Non-compliance with the Contract or applicable federal and state law or regulation.

5) Contractor has accrued claims that have not or will not be recompensed. Sanctions in the form of denial of payments provided for under the contract for new enrollees shall be taken, when and for as long as, payment for those enrollees is denied by CMS under 42 CFR 438.730.

E. The Director shall have the power and authority to take one or more of the following sanctions against Contractor for noncompliance:

1) Appointment of temporary management if Contractor has repeatedly failed to meet the contractual requirements or applicable Federal and state law or regulation. Contractor cannot delay appointment of temporary management to

provide a hearing before appointment. Temporary management will not be terminated until DHCS determines that Contractor's sanctioned behavior will not recur.

2) Suspension of all new enrollment, including default enrollment, or marketing activities after the effective date of the sanction;

3) Require Contractor to temporarily suspend or terminate personnel or subcontractors.

4) Take other appropriate action as determined necessary by DHCS.

17. ~~Professional Review System~~ Liquidated Damages

~~Use a professional review system in accordance with Title 22, CCR, Section 53280, for evaluating the appropriateness and quality of the Covered Services provided to Members and for periodically reviewing the performance of health and dental personnel, the utilization of services and facilities, costs, and the standards for acceptable medical and dental care.~~

A. General

The Director shall have the authority to impose liquidated damages on Contractor for failure to comply with the terms of this Contract as well as all applicable Federal and state law or regulation. Therefore, it is agreed by the state and Contractor that:

1) If Contractor does not provide or perform the requirements of this Contract or applicable laws and regulations, damage to the state shall result:

a. Proving such damages shall be costly, difficult, and time-consuming;

b. Should the state choose to impose liquidated damages, Contractor shall pay the state those damages for not providing or performing the specified requirements;

c. Additional damages may occur in specified areas by prolonged periods in which Contractor does not provide or perform requirements;

d. The damage figures listed below represent a good faith effort to quantify the range of harm that could reasonably be anticipated at the time of the making of the Contract;

e. DHCS may, at its discretion, offset liquidated damages from Capitation Payments owed to Contractor.

2) Imposition of liquidated damages as specified in paragraphs B. and C., below shall follow the administrative processes described below.

3) Before imposing sanctions, DHCS shall provide Contractor with written notice specifying the nature of the sanctions and the Contractor requirement(s), contained in the Contract or as required by federal and state law or regulation, not provided or performed,

4) Contractor shall demonstrate the provision or performance of Contractor's requirement(s) specified in the written notice within a 30 calendar day Corrective Action period from the date of the notice, unless a request for an extension is submitted to the Contracting Officer, subject to DHCS' approval, within five calendar days from the end of the Corrective Action period. If Contractor has not demonstrated the provision or performance of Contractor's requirement(s) specified in the written notice during the Corrective Action period, DHCS may impose liquidated damages for each day the specified Contractor's requirement is not performed or provided for the amount specified in paragraph C below.

5) If Contractor has not performed or provided Contractor's requirement(s) specified in the written notice or secured the written approval for an extension, after 30 calendar days from the first day of the imposition of liquidated damages, DHCS shall notify Contractor in writing of the increase of the liquidated damages to the amount specified in paragraph C. below.

Nothing in this provision shall be construed as relieving Contractor from performing any other Contract duty not listed herein, nor is the state's right to enforce or to seek other remedies for failure to perform any other Contract duty hereby diminished.

B. Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period.

DHCS may impose liquidated damages of $25,000 per requirement specified in the written notice for each day of the delay in completion or submission of Implementation Period requirements beyond the Implementation Period as specified in provision 11 above.

If DHCS determines that a delay or other non-performance was caused in part by the state, DHCS will reduce the liquidated damages proportionately.

The terms and sanctions provided in W&I Code section 14197.7 shall apply to PACE plans.

C. Liquidated Damages for Violation of Contract Terms or Regulations shall at a minimum include:

1) DHCS may impose liquidated damages of $2,500 per day for each violation of Contract requirement not performed in accordance with Exhibit A, Attachment 4, Quality Improvement System, provision 10 and / or paragraph D., until Contract requirement is performed or provided.

2) DHCS may impose liquidated damages of $3,500 per instance or case, per Medi-Cal Member if a Contractor fails to deliver the requested information in accordance with provision 23.

3) DHCS may impose liquidated damages of $3,500 per violation of Contract requirement not performed in accordance with Exhibit A, Attachment 6, provision 9.

4) DHCS may impose liquidated damages not to exceed $10,000 per violation of this Contract's requirements, as well federal and state law or regulation.

D. Conditions for Termination of Liquidated Damages

Except as waived by the Contracting Officer, no liquidated damages imposed on the Contractor will be terminated or suspended until the Contractor issues a written notice of correction to the Contracting Officer certifying, under penalty of perjury, the correction of condition(s) for which liquidated damages were imposed. Liquidated damages will cease on the day of the Contractor's certification only if subsequent verification of the correction by DHCS establishes that the correction has been made in the manner and at the time certified to by the Contractor.

The Contracting Officer will determine whether the necessary level of documentation has been submitted to verify corrections. The Contracting Officer will be the sole judge of the sufficiency and accuracy of any documentation. Corrections must be sustained for a reasonable period of at least 90 calendar days from DHCS acceptance; otherwise, liquidated damages may be reimposed without a succeeding grace period within which to correct. The Contractor's use of resources to correct deficiencies will not be allowed to cause other Contract compliance problems.

E. Severability of Individual Liquidated Damages Clauses

If any portion of these liquidated damages provisions is determined to be unenforceable, the other portions will remain in full force and effect.

18. Disputes

In addition to Exhibit C, provision 6~~. Disputes~~, Contractor also agrees to the following:

This Disputes section ~~shall~~ **will** be used by Contractor as the means of seeking resolution of disputes on contractual issues.

Filing a dispute shall not preclude DHCS from recouping the value of the amount in dispute from Contractor or from offsetting this amount from subsequent Capitation payment(s). If the amount to be recouped exceeds 25 percent of the Capitation payment, amounts of up to 25 percent ~~shall~~ **will** be withheld from successive Capitation payments until the amount in dispute is fully recouped~~. If a recoupment or offset is later found to be inappropriate, DHCS shall repay Contractor the full amount of recoupment or offset, plus interest at the Pooled Money Investment Rate pursuant to Government Code Section 16480 et. seq.~~

Exhibit E, Attachment 2
Program Terms and Conditions

A. Disputes Resolution by Negotiation

DHCS and Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contracting Officer level without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.

Before issuance of a Contracting Officer's decision, informal discussions between the parties by individuals who have not participated substantially in the matter in dispute shall be considered by the parties in efforts to reach mutual agreement.

B. Notification of Dispute

~~If the parties are not able to resolve a dispute by negotiation as set forth in this provision, paragraph A above w~~**W**ithin 15 **calendar** days ~~or any longer time as agreed by the parties, at its option,~~ **of the date the dispute concerning performance of this Contract arises or otherwise becomes known to the Contractor, the** Contractor ~~may~~ **will** notify the Contracting Officer in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which **it** is ~~in dispute~~ **disputing**.

Contractor's notification shall state, on the basis of the most accurate information then available to Contractor, the following:

1) That it is a dispute pursuant to this section~~.~~**:**

2) The date, nature, and circumstances of the conduct which is subject of the dispute~~.~~**;**

3) The names, phone numbers, function, and activity of each Contractor, subcontractor, DHCS/~~S~~**s**tate official or employee involved in or knowledgeable about the conduct~~.~~**;**

4) The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents ~~shall~~ **will** be attached~~.~~**;**

5) The reason Contractor is disputing the conduct~~.~~**;**

6) The cost impact to Contractor directly attributable to the alleged conduct, if any~~.~~**;**

7) Contractor's desired remedy.

The required documentation, including cost impact data, shall be carefully prepared and submitted with substantiating documentation by **the** Contractor. This documentation ~~shall~~ **will** serve as the basis for any subsequent Appeal.

Following submission of the required notification, with supporting documentation, Contractor ~~shall~~ **will comply with the requirements of California Code of Regulations, title 22, section 53851 (d) and** diligently continue performance of this Contract, including matters identified in the Notification of Disputes, to the maximum extent possible.

C. Contracting Officer's or Alternate Dispute Officer's Decision

Pursuant to a request by Contractor, the Contracting Officer may provide for a dispute to be decided by an alternate dispute officer designated by DHCS, who is not the Contracting Officer and is not directly involved in the Medi-Cal Managed Care Program. Any disputes concerning performance of this Contract shall be decided by the Contracting Officer or the alternate dispute officer in a written decision stating the factual basis for the decision. Within 30 days of receipt of a Notification of Dispute, the Contracting Officer or the alternate dispute officer shall either**:** ~~render a decision or shall request additional substantiating documentation from Contractor, which in the opinion of the Contracting Officer or alternate dispute officer is sufficient to allow the rendering of a decision. Within 30 days of receipt of the additional substantiating documentation requested, a decision shall be rendered. A copy of the decision shall be served on Contractor.~~

~~The Contracting Officer's or alternate dispute officer's decision shall:~~

1) Find in favor of Contractor, in which case the Contracting Officer or alternate dispute officer may:

   a. Countermand the earlier conduct which caused Contractor to file a dispute; or

   b. Reaffirm the conduct and, if there is a cost impact sufficient to constitute a change in obligations pursuant to the payment

provisions contained in Exhibit B~~, Budget Detail and Payment Provisions~~, direct DHCS to comply with that Exhibit; or

2) Deny Contractor's dispute and, where necessary, direct the manner of future performance; or

3) Request additional substantiating documentation in the event the information in Contractor's notification is inadequate to permit a decision to be made under 1) or 2) above, and shall advise Contractor as to what additional information is required, and establish how that information shall be furnished. Contractor shall have 30 days to respond to the Contracting Officer's or alternate dispute officer's request for further information. Upon receipt of this additional requested information, the Contracting Officer or ~~A~~ **a**lternate ~~D~~**d**ispute ~~O~~**o**fficer shall have 30 **calendar** days to respond with a decision. Failure to supply additional information required by the Contracting Officer or **a**lternate ~~D~~**d**ispute ~~O~~**o**fficer within the time period specified above shall constitute waiver by Contractor of all claims in accordance with paragraph F~~. Waiver of Claims~~**, below**.

A copy of the decision shall be served on Contractor.

D. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

Contractor shall have 30 calendar days following the receipt of the decision to file an Appeal of the decision to the Director. All Appeals ~~except as provided in this provision 18. paragraph C2 above~~ shall be governed by Health and Safety Code ~~S~~**s**ection 100171, except for those provisions of Section 100171**, subdivision**(d)**, criteria**(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All Appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An Appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An Appeal shall specifically set forth each issue in dispute, and include Contractor's contentions as to those issues. However, Contractor's Appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to paragraph B, Notification of Dispute **above**. Failure to timely Appeal the decision shall constitute a waiver by Contractor of all claims arising out of that conduct, in accordance with paragraph F, Waiver of Claims **below**. Contractor shall

exhaust all procedures provided for in this provision 18~~. Disputes~~, prior to initiating any other action to enforce this Contract.

E. Contractor Duty to Perform

Pending final determination of any dispute hereunder, Contractor shall **comply with the requirements of California Code of Regulations, title 22 section 53851 (d) and** proceed diligently with the performance of this Contract and in accordance with the Contracting Officer's or alternate dispute officer's decision.

If pursuant to an Appeal under paragraph D. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision, the Contracting Officer's or alternate dispute officer's decision is reversed, the effect of the decision pursuant to paragraph D. shall be retroactive to the date of the Contracting Officer's or alternate dispute officer's decision, and Contractor shall promptly receive any benefits of such decision. DHCS shall not pay interest on any amounts paid pursuant to a Contracting Officer's or alternate dispute officer's decision or any Appeal of such decision.

F. Waiver of Claims

If Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required information, or an Appeal of the Contracting Officer's or alternate dispute officer's decision, in the manner and within the time specified in this provision 18~~. Disputes~~, that failure shall constitute a waiver by Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

19. Audit

In addition to Exhibit C, provision 4~~. Audit~~, Contractor also agrees to the following:

Contractor shall maintain such books and records necessary to disclose how Contractor discharged its obligations under this Contract. These books and records shall disclose the quantity of Covered Services provided under this Contract, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the manner in which Contractor administered its daily business, and the cost thereof.

Exhibit E, Attachment 2
Program Terms and Conditions

A. Books and Records

These books and records ~~shall~~ **will** include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract including working papers~~;~~**,** reports submitted to DHCS~~;~~**,** financial records~~;~~**,** all Medical Records~~;~~**,** medical charts and prescription files~~;~~**,** and other documentation pertaining to medical and non-medical services rendered to Members.

B. Records Retention

Notwithstanding any other records retention time period set forth in this Contract, ~~T~~**t**hese books and records shall be maintained for a minimum of ~~six~~ **ten** years from the **final date of the Contract period or from the date of completion of any audit, whichever is later.** ~~termination date of this or in the event Contractor has been duly notified that the DHCS, DHHS or the Comptroller General of the United States or their duly authorized representatives have commenced an audit or investigation of the Contract, until such time as the matter under audit or investigation has been resolved, whichever is later.~~

Additional Recordkeeping Requirements:

1) In accordance with 42 CFR 438.3(u), Contractor shall retain the following information for no less than 10 years:

a. Member Grievance and Appeal records;

b. Base data;

c. MLR reports; and

d. Data, information

20. Inspection Rights

In addition to Exhibit D**(F)**, provision ~~8~~**2**~~. Site Inspection~~, Contractor also agrees to the following:

Through the end of the records retention period specified in Provision 19, Audit, Paragraph B., above, Contractor shall allow **the** DHCS, DHHS, the Comptroller General of the United States, **Department of Justice (DOJ), Bureau of Medi-Cal Fraud, DMHC,** and other authorized state agencies or their

duly authorized representatives **or designees, including DHCS' external quality review organization contractor,** to inspect**, monitor** or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all **premises,** books, records, ~~and~~ Facilities**, contracts, computers or other electronic systems,** maintained by Contractor and ~~s~~**S**ubcontractors, pertaining to such services at any ~~reasonable~~ time.

~~Books and r~~**R**ecords **and documents** include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract including working papers, reports, financial records and books of account, medical records, prescription files, **laboratory results,** subcontracts, **information systems and procedures,** and any other documentation pertaining to medical and non-medical ~~or dental~~ services ~~for~~ **rendered to** Members. Upon request, ~~at any time during the period of this Contract~~**, through the end of the records retention period specified in Provision 19, paragraph B, above**, Contractor shall furnish any ~~such~~ record, or copy ~~thereof~~ **of it**, to DHCS or any other entity listed in this section, at Contractor's sole expense. ~~At the discretion of DHCS unannounced visits may be made.~~

If DHCS, CMS, or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit a Subcontractor at any time.

A. Facility Inspections

DHCS shall conduct unannounced validation reviews on a number of Contractor's Primary Care sites, selected at DHCS' discretion, to verify compliance of these sites with DHCS requirements.

B. Access Requirements and State's Right To Monitor

~~The State shall~~ **Authorized state and Federal agencies will** have the right to monitor all aspects of Contractor's operation for compliance with the provisions of this Contract and applicable federal and ~~S~~**s**tate laws and regulations. Such monitoring activities ~~shall~~ **will** include, but are not limited to, inspection and auditing of Contractor, ~~s~~**S**ubcontractor, and provider Facilities, management systems and procedures, and books and records as the Director deems appropriate~~, at any time during Contractor's or other Facility's normal business hours~~. The monitoring activities ~~shall~~ **may** be either announced or unannounced.

Exhibit E, Attachment 2
Program Terms and Conditions

To assure compliance with the Contract and for any other reasonable purpose, the ~~S~~**s**tate and its authorized representatives and designees shall have the right to premises access, with or without notice to Contractor. This shall include the MIS operations site or such other place where duties under the Contract are being performed.

Staff designated by ~~the~~ **authorized** ~~S~~**s**tate **agencies** ~~or DHCS shall~~ **will** have access to all security areas and Contractor ~~shall~~ **will** provide, and ~~shall~~ **will** require any and all of its subcontractors to provide, reasonable Facilities, cooperation, and assistance to ~~S~~**s**tate representative(s) in the performance of their duties. Access ~~shall~~ **will** be undertaken in such a manner as to not unduly delay the work of Contractor and/or the ~~s~~ **S**ubcontractors(s).

21. Confidentiality of Information

In addition to Exhibit D**(F)**, provision **14**~~13. Confidentiality of Information~~, Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

A. Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with ~~Title~~ 42, CFR, ~~Section~~ 431.300 et seq., **Welfare and Institutions** ~~W&I~~ Code, ~~S~~**s**ection 14100.2, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Contractor from unauthorized disclosure.

Contractor may release Medical Records in accordance with applicable law~~s~~ pertaining to the release of this type of information. **Contractor is not required to report requests for Medical Records made in accordance with applicable law.**

B. With respect to any identifiable information concerning a Member under this Contract that is obtained by Contractor or its subcontractors, **the** Contractor: (1) ~~shall~~ **will** not use any such information for any purpose other than carrying out the express terms of this Contract~~,~~**;** (2) ~~shall~~ **will** promptly transmit to DHCS all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law~~,~~**;** (3) ~~shall~~ **will** not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS without DHCS' prior written authorization specifying that the information is

releasable under ~~Title~~ 42, CFR, ~~Section~~ 431.300 et seq., W**elfare and Institutions** ~~&I~~ Code, S**s**ection 14100.2, and regulations adopted thereunder~~,~~**;** and (4) ~~shall~~ **will**, at the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to **the** Contractor by DHCS for this purpose.

22. Pilot Projects

DHCS may establish pilot projects to test alternative models tailored to suit the needs of populations with special health care needs. The operation of these pilot projects may result in the disenrollment of Members that participate. Implementation of a pilot project may affect the Contractor's obligations under this Contract. Any changes in the obligations of the Contractor that are necessary for the operation of a pilot project in the Contractor's Service Area will be implemented through a contract amendment.

22. Assignments

Contractor shall not assign the Contract, in whole or in part, without the prior written approval of DHCS.

23. Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources (OHCS)

A. Contractor shall Cost Avoid or make a Post-Payment Recovery for the reasonable value of services paid for by Contractor and rendered to a Member whenever a Member's OHCS covers the same services, either fully or partially. However, in no event shall Contractor Cost Avoid or seek Post-Payment Recovery for the reasonable value of services from a ~~Third-Party Tort Liability (~~TPTL~~)~~ action or make a claim against the estates of deceased Members.

B. Contractor retains all monies recovered by Contractor.

C. Contractor shall coordinate benefits with other coverage programs or entitlements, recognizing the OHCS as primary and the Medi-Cal program as the paye**e**r of last resort.

D. Cost Avoidance

1) If Contractor reimburses the provider on a ~~fee-for-service~~ **FFS** basis, Contractor shall not pay claims for services provided to a

Member whose Medi-Cal eligibility record indicates third party coverage, designated by a Other Health Coverage (OHC) code or Medicare coverage, without proof that the provider has first exhausted all sources of other payments. Contractor shall have written procedures implementing this requirement.

2) Proof of third party billing is not required prior to payment for services provided to Members with OHC codes A, M, X, Y, or Z.

E. Post-Payment Recovery

1) If Contractor reimburses the provider on a ~~fee-for-service~~ **FFS** basis, Contractor shall pay the provider's claim and then seek to recover the cost of the claim by billing the liable third parties for services provided to Members with OHC codes A, M, X, Y, or Z.

2) In instances where Contractor does not reimburse the provider on a ~~fee-for-service~~ **FFS** basis, Contractor shall pay for services provided to a Member whose eligibility record indicates third party coverage, designated by a OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual services rendered.

3) Contractor shall also bill the liable third parties for the cost of services provided to Members who are retroactively identified by Contractor or DHCS as having OHC.

4) Contractor shall have written procedures implementing the above requirements.

F. Contractor shall initiate a Disenrollment for all Members whose eligibility record indicates OHC codes C, F, K, or P, within three ~~S~~**s**tate working days after Contractor becomes aware of the OHC code. Until the Member is disenrolled, Contractor shall Cost Avoid or seek Post-Payment Recovery as specified in paragraphs D**.** and E**.** above.

G. Reporting Requirements

1) Contractor shall ~~submit monthly reports to DHCS, in a format prescribed by DHCS,~~ **maintain reports that** display~~ing~~ claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of

account. The report shall display separate claim counts and dollar amounts for Medicare Part**s** A**,** ~~and Part B~~ **and D**. Reports shall be ~~sent to the Department of Health Care Services, Third Party Liability Division, Cost Avoidance Unit, P.O. Box 2471, Sacramento, CA 95812-2471~~ **made available upon DHCS request**.

2) When Contractor identifies OHC unknown to DHCS, Contractor shall report this information to DHCS within **ten** ~~(10)~~ **calendar** days of discovery in automated format as prescribed by DHCS. This information shall be sent to the Department of Health Care Services, Third Party Liability ~~Division~~ **Branch**, Other Coverage Unit, P.O. Box 997422, Sacramento, CA 95899-7422.

3) Contractor shall demonstrate to DHCS that where Contractor does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues Contractor projects it would receive from such activity.

24. Third-Party Tort Liability

Contractor shall identify and notify DHCS' Third Party Liability Division of all instances or cases in which Contractor believes an action by the Medi-Cal Member involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Member of funds to which DHCS has lien rights under ~~Article 3.5 (commencing with Section 14124.70), Part 3, Division 9,~~ Welfare and Institutions Code **section 14124.70**. Contractor shall make no claim for recovery of the value of Covered Services rendered to a Member in such cases or instances and such case or instance shall be referred to DHCS' Third Party Liability ~~Division~~ **Branch** within **ten** ~~(10)~~ **calendar** days of discovery. To assist DHCS in exercising its responsibility for such recoveries, Contractor shall meet the following requirements:

A. If DHCS requests service information and/or copies of paid invoices/claims for Covered Services to an individual Member, Contractor shall deliver the requested information within 30 **calendar** days of the request. Service information includes subcontractor and out-of-plan provider data. The value of the Covered Services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to subcontracted providers or out-of-plan providers for similar services.

B. Information to be delivered shall contain the following data items:

1) Member name~~.~~**;**

2) Full 14 digit Medi-Cal number~~.~~**;**

3) Social Security Number~~.~~**;**

4) Date of birth~~.~~**;**

5) Contractor name~~.~~**;**

6) Provider name (if different from Contractor)~~.~~**;**

7) Dates of service~~.~~**;**

8) Diagnosis code and description of illness/injury~~.~~**;**

9) Procedure code and/or description of services rendered~~.~~**;**

10) Amount billed by a subcontractor or out-of-plan provider to Contractor (if applicable)~~.~~**;**

11) Amount paid by other health insurance to Contractor or subcontractor (if applicable)~~.~~**;**

12) Amounts and dates of claims paid by Contractor to subcontractor or out-of-plan provider (if applicable)~~.~~**;**

13) Date of denial and reasons for denial of claims (if applicable)~~.~~**; and**

14) Date of death (if applicable)~~.~~

C. Contractor shall identify to DHCS' Third Party Liability ~~Division~~ **Branch** the name, address**,** and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

D. If Contractor receives any requests from attorneys, insurers or beneficiaries for copies of bills, Contractor shall ~~provide DHCS'~~ **refer the request to the** Third Party Liability ~~Division~~ **Branch** with ~~a copy of any document released as a result of such request,~~ **the information contained in paragraph B., above,** and shall provide the name, address and telephone number of the requesting party.

E. Information submitted to DHCS under this section shall be sent to **the California** Department of Health Care Services, Third Party Liability ~~Division~~ **Branch**, Recovery Section, **MS 4720,** P.O. Box ~~2471~~ **997425**, Sacramento, CA ~~95812-2471~~ **95899-7425**.

25. Records Related To Recovery ~~F~~for Litigation

A. Records

Upon request by DHCS, Contractor shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in Contractor's or its subcontractors' possession, relating to threatened or pending litigation by or against DHCS. (If Contractor asserts that any requested documents are covered by a privilege, Contractor shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document.) Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Contractor acknowledges that time may be of the essence in responding to such **a** request. Contractor shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records, received by Contractor or its Subcontractors related to this Contract or Subcontracts entered into under this Contract.

B. Payment for Records

In addition to the payments provided for in Exhibit B~~, Budget Detail and Payment Provisions~~, DHCS agrees to pay Contractor for complying with paragraph A**.** ~~, Records~~, above, as follows:

1) DHCS shall reimburse Contractor amounts paid by Contractor to third parties for services necessary to comply with paragraph A. Any third party assisting Contractor with compliance with paragraph A**.** above, shall comply with all applicable confidentiality requirements. Amounts paid by Contractor to any third party for assisting Contractor in complying with paragraph A**.**, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by DHCS.

2) If Contractor uses existing personnel and resources to comply with paragraph A**.**, DHCS shall reimburse Contractor as specified below. Contractor shall maintain and provide to DHCS time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by DHCS.

a.) Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to paragraph A.

b.) Costs for copies of all documentation submitted to DHCS pursuant to paragraph A**.**, subject to a maximum reimbursement of **ten** (10) cents per copied page.

3) Contractor shall submit to DHCS all information needed by DHCS to determine reimbursement to Contractor under this provision, including, but not limited to, copies of invoices from third parties and payroll records.

26. Fraud and Abuse Reporting

A. Fraud and Abuse Reporting **For purposes of the exhibit, the following definitions apply:**

Contractor is considered a mandated reporter pursuant to W&I Code, Section 15630(b) and shall comply with the provisions therein.

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2; Welfare and Institutions Code section 14043.1(a).)

Conviction or Convicted means that a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending (42 CFR 455.2). This definition also includes the definition of the term "convicted" in Welfare and Institutions Code section 14043.1(f).

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law (42 CFR 455.2; Welfare and Institutions Code section 14043.1(i).)

B. **Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse. These requirements shall be met through the following:**

1) **Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.**

2) **Contractor shall provide effective training and education for the compliance officer and all employees.**

3) **Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.**

4) **Fraud and Abuse Reporting**

Contractor shall report to the ~~Contracting Officer~~ **DHCS** all cases of suspected fraud and/or abuse, ~~as defined in 42 CFR, Section 455.2,~~ where there is reason to believe that an incident of fraud and/or abuse has occurred, by ~~s~~**S**ubcontractors, Members, providers, or employees. **Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten working days of the date Contractor first becomes aware of, or is on notice of, such activity**. ~~within 10 State working days of the date when Contractor first becomes aware of or is on notice of such activity.~~

Exhibit E, Attachment 2
Program Terms and Conditions

~~Contractor shall establish policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program. Contractor shall notify DHCS prior to conducting any investigations, based upon Contractor's finding that there is reason to believe that an incident to fraud and/or abuse has occurred, and, upon the request of DHCS, consult with DHCS prior to conducting such investigations. Without waiving any privileges of Contractor, Contractor shall report investigation results within 10 State working days of conclusion of any fraud and/or abuse investigation.~~

Fraud reports submitted to DHCS must, at a minimum, include:

a. Number of complaints of fraud and abuse submitted that warranted preliminary investigation.

b. For each complaint which warranted a preliminary investigations, supply:

i) name and/or SSN or CIN;

ii) source of complaint;

iii) type of provider (if applicable);

iv) nature of complaint;

v) approximate dollars involved; and

vi) legal and administrative disposition of the case

The report shall be submitted on a Confidential Medi-Cal Complaint Report (MC 609) that can be sent to DHCS in one of three ways:

a. Email at PIUCases@DHCS.ca.gov;

b. E-fax at (916) 440-5287; or

c. U.S. Mail at:

Department of Health Care Services

Integrated Systems of Care Division
Attention: Contract Management Unit
P.O. Box 997437
MS 4502
Sacramento, CA 95899-7437

Contractor shall submit the following components with the report or explain why the components are not submitted with the report: police report, health plan's documentation (background information, investigation report, interviews, and any additional investigative information), Member information (patient history chart, Patient profile, Claims detail report), provider enrollment data, Confirmation of services, list items or services furnished by the provider, Pharmaceutical data from manufacturers, wholesalers and retailers and any other pertinent information.

5) Tracking Suspended Providers

Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. A list of suspended and ineligible providers is maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal Web site (http://www.medi-cal.ca.gov) and by the DHHS, Office of Inspector General, List of Excluded Individuals and Entities (http://oig.hhs.gov). Contractor is deemed to have knowledge of any providers on these lists. Contractor must notify the Integrated Systems of Crae Division Contract Management Unit within ten state working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program. A removed, suspended, excluded, or terminated provider report can be sent to DHCS in one of three ways:

a. Email at PIUCases@DHCS.ca.gov;

b. E-fax at (916) 440-5287; or

c. U.S. Mail at:

Department of Health Care Services
Integrated Systems of Care Division
Attention: Contract Management Unit
P.O. Box 997437
MS 4502
Sacramento, CA 95899-7437

~~B~~**C**. Federal False Claim Act Compliance

Contractor shall comply with 42 U**.**S**.**C**.**, ~~S~~**s**ection 1396(a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this Contract. Upon request by DHCS, Contractor shall demonstrate compliance with this provision, which may include providing DHCS with copies of Contractor's applicable written policies and procedures and any relevant employee handbook excerpts.

27. Equal Opportunity Employer

~~In addition to Exhibit D, provision 1. Federal Equal Employment Opportunity requirements, the Contractor also agrees to the following:~~

Contractor ~~shall~~ **will**, in all solicitations or advertisements for employees placed by or on behalf of **the** Contractor, state that it is an equal opportunity employer, and shall send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by DHCS, advising the labor union or workers' representative of Contractor's commitment as an equal opportunity employer and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

28. Discrimination Prohibitions

A. Member Discrimination Prohibition

Contractor shall not **unlawfully** discriminate against Members or Eligible Beneficiaries because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, **ethnic group identification**, age, sex**,** ~~or~~ physical or mental ~~handicap~~ **disability, medical condition, genetic information, gender, or gender identity,** in accordance with **section 1557 of the Patient Protection and Affordable Care Act of 2010, the Americans with Disabilities Act of 1990,** Title VI of the Civil

Exhibit E, Attachment 2
Program Terms and Conditions

Rights Act of 1964, **Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended)**; **the Age Discrimination Act of 1975**; **the Rehabilitation Act of 1973**, **as amended; the Americans with Disabilities Act of 1990, as amended, Section 11135 of the Government Code, Sections 14029.91 and 14029.92 of the Welfare and Institutions Code,** ~~(42 U.S.C. Section§ 2000d,)~~ rules and regulations promulgated pursuant thereto, or as otherwise provided by **federal or state** law or regulations. For the purpose of this Contract, discrimination **includes**, ~~s on the grounds of race, color, creed, religion, ancestry, age, sex, national origin, marital status, sexual orientation, or physical or mental handicap include,~~ but ~~are~~ is not limited to, the following:

1) Denying any Member any Covered Services or availability of a Facility~~.~~**;**

2) Providing to a Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated~~.~~;

3) Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service~~.~~**;**

4) Restricting a Member in anyway in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or Eligible Beneficiary differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership or other requirement or condition which individuals must meet in order to be provided any Covered Service~~.~~**; or**

5) The assignment of times or places for the provision of services on the basis of the **sex**, race, color, creed, religion, **ethnic group identification,** age, ~~sex~~ **gender**, national origin, ancestry, marital status, sexual orientation, **gender identity, physical or mental disability , medical condition, or genetic information** ~~or the physical or mental handicap~~ of the **members** to be served.

Contractor shall take affirmative action to ensure that Members are provided Covered Services without regard to **sex**, race, color, creed, religion, **ethnic group identification**, ~~sex~~ **gender**, national origin, ancestry, marital status, sexual orientation, **gender identity, physical**

Back to Agenda Back to Item

disability, mental disability,medical condition, or genetic information~~, or physical or mental handicap~~, except where medically indicated.

For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes shall include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

B. Discrimination Related To Health Status

Contractor shall not discriminate among eligible individuals on the basis of their health status requirements or requirements for health care services during Enrollment, re-enrollment or Disenrollment. Contractor ~~shall~~ **will** not terminate the Enrollment of an eligible individual based on an adverse change in the Member's health.

~~C. Discrimination Complaints~~

~~Contractor agrees that copies of all Grievances alleging discrimination against Members or Eligible Beneficiaries because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, or physical or mental handicap shall be forwarded to DHCS for review and appropriate action.~~

29. ~~Americans With Disabilities Act Of 1990~~ Additional Federal Requirements

~~This provision supplements the Americans with Disabilities Act information appearing in the Contractor Certification Clause (CCC 307).~~

Contractor shall comply with all applicable federal requirements in ~~Section 504 of the Rehabilitation Act 1973 and the Americans with Disabilities Act of 1990 (42 USC, Section 12100 et seq.), Title 45, CFR, Part 84 and Title 28, CFR, Part 36~~ **Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990, as amended; and Section 1557 of the Patient Protection and Affordable Care Act.**

30. Binding Arbitration

If Contractor uses binding arbitration to settle disputes, Contractor shall disclose this in all of Contractor's Marketing presentations and materials, new enrollee information, Member Enrollment Agreement Terms and Conditions, disclosure form, and any other informing materials, pursuant to the California **Welfare and Institutions** ~~W&I~~ Code, ~~S~~**s**ection 14450, ~~the California~~ Health ~~and~~ **&** Safety Code, ~~S~~**s**ections 1363 and 1363.1 and the California Code of Civil Procedure~~s,~~ ~~S~~**s**ection 1295.

Contractor shall comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at section 10115 of the Public Contract Code.

31. Word Usage

Unless the context of this Contract clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and neuter genders shall each be deemed to include the others; (c) "shall," "~~shall~~ **will**," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

32. Federal False Claims Act Compliance

Effective January 1, 2007, Contractor shall comply with 42USC Section 1396a(a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this Contract. Upon request by DHCS, Contractor shall demonstrate compliance with this provision, which may include providing DHCS with copies of Contactor's applicable written policies and procedures and any relevant employee handbook excerpts.

33. State Hearings

Contractor shall provide written position statements whenever notified by DHCS that a Member has requested a ~~S~~**s**tate hearing. Contractor also shall designate staff to make testimony at ~~S~~**s**tate hearings whenever notified by DHCS of the scheduled time and place for a ~~S~~**s**tate hearing. Contractor responsibilities regarding ~~S~~**s**tate hearings are pursuant to **Welfare and Institutions** ~~W&I~~ Code, ~~S~~**s**ections 10950 through 10962, and **California Code of Regulations,** ~~T~~**t**itle 22, ~~CCR,~~ ~~S~~**s**ections 51014.1, 51014.2, 53261 and 53452. Additional clarification of Contractor responsibilities related to ~~S~~**s**tate hearings shall be provided to Contractor by DHCS.

34. Federal Oversight Requirements

Exhibit E, Attachment 2
Program Terms and Conditions

The Contractor is considered a contractor, and not a subrecipient for the purposes of the U.S. Office of Management and Budget Uniform Guidance (Title 2 of the Code of Federal Regulations, Part 200, and, specifically, 2 CFR 200.330).

~~**33. Program Information**~~

~~Contractor shall obtain complete and current information with respect to pertinent statutes, regulations and procedure manuals affecting the operation of this Contract and Subcontracts.~~

~~**34. Compliance With Protocols**~~

~~Contractor shall develop the protocols and procedures specified in this Contract and shall comply with them within 30 days of their approval by DHCS. All subsequent revisions thereof shall be approved by DHCS and implemented by Contractor within 30 days of such approval in accordance with Title 22, CCR, Sections 53100, 53280, and 53500. Contractor shall not implement protocols, procedures or revisions thereof prior to approval by DHCS.~~

~~**35. Reimbursement and Operations Reliance**~~

~~Contractor shall not commence operations nor receive reimbursement under this Contract prior to obtaining DHCS approval of Contractor's application, including its health care delivery system, managed care organization, Marketing, and administrative systems, and execution of necessary Subcontracts for operation as a health plan.~~

Exhibit E, Attachment 3
Duties of the State

1. Payment For Services

DHCS shall pay the appropriate Capitation payments set forth in Exhibit B, Attachment 1~~, Rate of Medi-Cal Reimbursement and Exhibit B, Attachment 2, Capitation Rate Sheets,~~ to **the** Contractor for each eligible Member under this Contract, and ensure that such payments are **based on actuarially sound capitation rates defined in 42 CFR, Section 438.6(c).** ~~Such p~~**P**ayments ~~are to~~ **will** be made monthly for the duration of this Contract.

2. Medical Reviews

DHCS shall conduct medical reviews in accordance with ~~the provisions of~~ **Welfare and Institutions** ~~W&I~~ Code, ~~S~~**s**ection 14456~~, and issue medical review reports to Contractor detailing findings, recommendations, and corrective action, as appropriate~~. **DHCS shall have the discretion to accept plan performance reports, audits or reviews conducted by other agencies or accrediting bodies that use standards comparable to those of DHCS. These plan performance reports, audits and reviews may be in lieu of an audit or review conducted by DHCS in order to eliminate duplication of auditing efforts.**

3. Enrollment Processing

DHCS shall review applications for Enrollment submitted by Contractor~~,~~ **and** verify the eligibility of all applicants for Enrollment in Contractor's plan under this Contract. DHCS shall provide to Contractor a list of Members on a monthly basis.

4. Disenrollment Processing

DHCS shall review and process requests for Disenrollment. On an annual basis, provide in writing a schedule of the last calendar dates in each month by which requests for Disenrollment must be submitted to ~~the~~ DHCS by Contractor to assure that Disenrollment occurs in compliance with **Welfare and Institutions** ~~W&I~~ Code, ~~S~~**s**ection 14413. DHCS may revise the schedule, as necessary, to assure that the requirements of **Welfare and Institutions** ~~W&I~~ Code, ~~S~~**s**ection 14413 are met. DHCS shall provide reasonable notice to Contractor of revisions to the schedule.

Exhibit E, Attachment 3
Duties of the State

5. DHCS Approval Process

A. Within five ~~(5) State~~ working days of receipt, DHCS shall acknowledge in writing the receipt of any material sent to DHCS by Contractor pursuant to Exhibit E, Attachment 2, provision 8. ~~Obtaining DHCS Approval.~~

B. Within 60 **calendar** days of receipt, DHCS shall make all reasonable efforts to approve in writing the use of such material provided to DHCS pursuant to Exhibit E, Attachment 2, provision 8~~. Obtaining DHCS Approval.~~ **and** ~~P~~**p**rovide Contractor with a written explanation why its use is not approved or provide a written estimated date of completion of DHCS' review process. If DHCS does not complete its review of submitted material within 60 **calendar** days of receipt or within the estimated date of completion of DHCS review, Contractor may elect to implement or use the material at Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This paragraph shall not be construed to imply DHCS approval of any material that has not received written DHCS approval. This paragraph shall not apply to Subcontracts or sub-subcontracts subject to DHCS approval in accordance with Exhibit A, Attachment 6, provision **12**~~.~~ **paragraph B**. ~~Subcontract Requirements~~, paragraph B~~, Departmental Approval~~.

6. DHCS Program Information

DHCS shall provide Contractor with complete and current information with respect to pertinent policies, procedures, and guidelines affecting the operation of this Contract, within 30 **calendar** days of receipt of Contractor's written request for information, to the extent that the information is readily available. If the requested information is not available, DHCS shall notify Contractor within 30 **calendar** days, in writing, of the reason for the delay and when Contractor may expect the information.

7. DHCS Catastrophic Coverage Limitation

DHCS shall limit Contractor's liability to provide or arrange and pay for care for illness of or injury to~~,~~ Members which results from or is greatly aggravated by, a catastrophic occurrence or disaster.

8. Risk Limitation

DHCS **and Contractor** agree~~s~~ there shall be no risk limitation and **that** Contractor ~~shall~~ **will** have full financial liability to provide **Medically Necessary**

Exhibit E, Attachment 3
Duties of the State

Covered Services to ~~enrolled beneficiaries~~ **members as provided by the Contract and federal and state law**.

9. Notice Of Termination Of Contract

~~No later than 60 days prior to the termination or expiration of the Contract,~~ DHCS shall notify Members about their ~~medical~~ **health care** benefits and available options **upon termination or expiration of this Contract**.

10. Testing of Marketing Representatives

DHCS shall test all Contractor Marketing Representatives for knowledge of the program following completion of a comprehensive training program conducted by Contractor and prior to their engaging in Marketing or Medi-Cal Managed Care information activities on behalf of Contractor. Qualified Marketing Representatives are those persons demonstrating adequate knowledge of the program after completing the training program conducted by Contractor and passing the Medi-Cal Marketing exam administered by DHCS.

11. Policy Letters

DHCS shall provide applicable Policy Letters to Contractor as deemed necessary.

12. Review and Evaluation

Review and evaluate, relative to provider operations and costs, all reports submitted by Contractor under the provisions of Exhibit A, Attachment 17~~, Reporting Requirements~~.

Exhibit E
Additional Provisions

1. Additional Incorporated Exhibits

The following additional exhibits are attached, incorporated herein, and made a part hereof by this reference:

A.	Exhibit A, Attachment 1 - Organization and Administration of the Plan	~~4 pages~~
B.	Exhibit A, Attachment 2 - Financial Information	~~4 pages~~
C.	Exhibit A, Attachment 3 - Management Information System	~~1 page~~
D.	Exhibit A, Attachment 4 - Quality Improvement System	~~13 pages~~
E.	Exhibit A, Attachment 5 - Utilization Management	~~1 page~~
F.	Exhibit A, Attachment 6 - Provider Network	~~6 pages~~
G.	Exhibit A, Attachment 7 - Provider Relations	~~3 pages~~
H.	Exhibit A, Attachment 8 - Provider Compensation Arrangements	~~4 pages~~
I.	Exhibit A, Attachment 9 - Access and Availability	~~6 pages~~
J.	Exhibit A, Attachment 10 - Scope of Services	~~8 pages~~
K.	Exhibit A, Attachment 11 - Case Management and Coordination of Care	~~2 pages~~
L.	Exhibit A, Attachment 12 – ~~This Attachment Intentionally Left Blank~~ **Local Health Department Coordination**	~~1 page~~
M.	Exhibit A, Attachment 13 - Member Services	~~6 pages~~
N.	Exhibit A, Attachment 14 - Member Grievance and Appeals	~~4 pages~~
O.	Exhibit A, Attachment 15 - Marketing	~~6 pages~~
P.	Exhibit A, Attachment 16 - Enrollments and Disenrollments	~~5 pages~~
Q.	Exhibit A, Attachment 17 - Reporting Requirements	~~3 pages~~

2. Priority of Provisions

In the event of a conflict between the provisions of Exhibit E and any other exhibit of this Contract, excluding Exhibit C, the provisions of Exhibit E shall prevail.

Exhibit X
Business Associate Addendum

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations, Parts 160 and 164 (collectively, and as used in this Agreement)

2. The term “Agreement” as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term “Business Associate” shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by Federal and/or state laws.

4.1 As used in this Agreement and unless otherwise stated, the term “PHI” refers to and includes both “PHI” as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

4.2 As used in this Agreement, the term “confidential information” refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which state and/or federal privacy and/or security protections apply.

5. Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, “use or disclose PHI”) in order to fulfill Business Associate’s obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties.”

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

7. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA if done by DHCS.

7.1 **Specific Use and Disclosure Provisions**. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

8. **Compliance with Other Applicable Law**

8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

9.1 Nondisclosure. Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.2 Safeguards and Security.

9.2.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be, at a minimum, at Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.2.2 Business Associate shall, at a minimum, utilize an industry-recognized security framework when selecting and implementing its security controls, and shall maintain continuous compliance with its selected framework as it may be updated from time to time. Examples of industry-recognized security frameworks include but are not limited to

9.2.2.1 NIST SP 800-53 – National Institute of Standards and Technology Special Publication 800-53

9.2.2.2 FedRAMP – Federal Risk and Authorization Management Program

9.2.2.3 PCI – PCI Security Standards Council

9.2.2.4 ISO/ESC 27002 – International Organization for Standardization / International Electrotechnical Commission standard 27002

9.2.2.5 IRS PUB 1075 – Internal Revenue Service Publication 1075

9.2.2.6 HITRUST CSF – HITRUST Common Security Framework

9.2.3 Business Associate shall maintain, at a minimum, industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.2.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

9.2.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.3 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. **Mitigation of Harmful Effects**. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. **Access to PHI.** Business Associate shall make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. **Accounting for Disclosures.** Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. **Compliance with DHCS Obligations.** To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

15. **Access to Practices, Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.

16. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

17. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

18. **Breaches and Security Incidents.** Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS.

18.1.1 Business Associate shall notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to DHCS.

18.1.2 Business Associate shall notify DHCS **within 24 hours by email** (or by telephone if Business Associate is unable to email DHCS) of the discovery of:

18.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

18.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

18.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

18.1.2.4 Potential loss of confidential data affecting this Agreement.

18.1.3 Notice shall be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information at Section 18.6. below.

Notice shall be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and shall include all information known at the time the incident is reported. The form is available online at http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

18.2 Investigation. Business Associate shall immediately investigate such security incident or confidential breach.

18.3 Complete Report. To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR" must include any applicable additional information not included in the Initial Form. The Final PIR Form shall include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate shall make reasonable efforts to provide DHCS with such information. A "Supplemental PIR" may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is

reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate shall request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 Notification of Individuals. If the cause of a breach is attributable to Business Associate or its agents, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

18.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its subcontractors, Business Associate is responsible for all required reporting of the breach as required by applicable federal and state law.

18.6 DHCS Contact Information. To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

DHCS Program Contract Manager	**DHCS Privacy Office**	**DHCS Information Security Office**
See the Scope of Work exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. Responsibility of DHCS. DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

20. Audits, Inspection and Enforcement

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

21. Termination

21.1 Termination for Cause. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 Judicial or Administrative Proceedings. DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 Disclaimer. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. Amendment.

22.2.1 Any provision of this Agreement which is in conflict with current or future applicable Federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 No Third-Party Beneficiaries. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 Interpretation. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 No Waiver of Obligations. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

CalOptima Board Action Agenda Referral

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contacts

Silver Ho, Executive Director, Compliance, (657) 235-6997
TC Roady, Director, Regulatory Affairs & Compliance, (714) 796-6122

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute Amendments to the Primary and Secondary Agreements between the California Department of Health Care Services and CalOptima to extend the termination dates of the agreements

Background

As a County Organized Health System (COHS), CalOptima contracts with the California Department of Health Care Services (DHCS) to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year primary 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 ensure that assigned members have access to covered, medically necessary health care services. The Secondary Agreement's effective and expiration dates are consistent with CalOptima's Primary Agreement.

Discussion

Extension of the Termination Dates of the Primary and Secondary Agreements

On Friday, October 9, 2020, DHCS provided copies of the amendments and requested prompt execution and return by Friday, November 6, 2020. The amendments will extend the termination dates of CalOptima's Primary and Secondary Agreements to December 31, 2021 from the current termination date of December 31, 2020.

DHCS had historically extended agreements with CalOptima by a single calendar year, but it informed CalOptima on November 9, 2016 that the Centers for Medicare & Medicaid Services (CMS) had allowed DHCS to extend CalOptima's contract for a longer term until December 31, 2020. The CalOptima Board previously authorized and directed the Board Chair to execute an extension to the Primary and Secondary Agreements to December 31, 2020 during its December 2016 meeting. In order to ensure timely execution of the extensions, staff is requesting that the Board authorize and direct the Chair to execute amendments extending the Primary and Secondary agreements through December 31, 2021. If the amendments are not consistent with this understanding, or if the amendments include substantive and unexpected language changes, staff will return to the Board with further recommendations.

Back to Agenda

Fiscal Impact

The recommended action to execute amendments to the Primary and Secondary Agreements with DHCS to extend the termination dates to December 31, 2021 is a budgeted item, with no additional fiscal impact through June 30, 2021. Management plans to include funding for the period of July 1, 2021 through the contract end date in future operating budgets.

Rationale for Recommendation

The extensions of the Primary and Secondary Agreements with DHCS for Medi-Cal are necessary for the continued operation of CalOptima's Medi-Cal program.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Appendix Summary of Amendments to Primary and Secondary Agreements with DHCS

/s/ Richard Sanchez *10/28/2020*

Authorized Signature **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM 6

The following is a summary of amendments to the Primary Agreement approved by the CalOptima Board of Directors (Board) to date:

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

Back to Agenda Back to Item

A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A-45 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019

The following is a summary of amendments to the Secondary Agreement approved by the CalOptima Board of Directors (Board) to date:

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010

A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval

A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

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

Contacts
David Ramirez, M.D., Chief Medical Officer, (714) 347-3261
Tracy Hitzeman, RN, Executive Director, Clinical Operations, (714) 246-8549
Kris Gericke, Pharm.D., Director, Clinical Pharmacy Management, (714) 246-8460

Recommended Actions
Authorize the Chief Executive Officer (CEO) to modify the following existing medical policies and procedures in connection with CalOptima's regular review process and consistent with regulatory requirements, as follows:

1. Policy GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B) [Medi-Cal, OneCare Connect];

2. Policy GG.1810: Bed Hold, Long-Term Care [Medi-Cal, OneCare Connect];

3. Policy GG.1321: Coordination of Care for Local Education Agency Services [Medi-Cal];

4. Policy MA.6044: Coverage of Solid Organ and Stem Cell Transplants [OneCare, OneCare Connect]; and

5. Policy MA.6101: Medicare Part D Coverage Determination [OneCare, OneCare Connect]

Background/Discussion
CalOptima regularly reviews its Policies and Procedures to ensure they are up-to-date and aligned with Federal and State health care program requirements, contractual obligations and laws as well as CalOptima operations.

Below is information regarding the policies that require modification:

1. ***Policy GG. 1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)*** describes the requirements for processing admission, continued stay or discharge authorizations for Long-Term Care NF-A and NF-B levels of care. Language was clarified throughout the policy. The policy was updated to include timeframes for decision-making, a description of the off-site level of care determination process, documentation of LOA requirements and reference to DHCS standard clinical criteria. The requirement to review any request that does not meet clinical criteria for NF-B against NF-A criteria for possible approval at a modified level of care was included.

Back to Agenda

2. ***Policy GG.1810: Bed Hold, Long-Term Care*** defines the process for Long-Term Care (LTC) Bed Holds. Updates included removing the requirement for authorization for LTC bed holds, while retaining the requirement for Members admitted for short stay services (nursing facility stays less than 90 days).

3. ***Policy GG.1321: Coordination of Care for Local Education Agency Services*** defines the guidelines for coordination of care for a Member eligible for services from a Local Education Agency (LEA). Revisions to the policy provide clarification that services covered through an LEA are not Covered Services under CalOptima's contract with the Department of Health Care Services. Additional detail added to describe how CalOptima and its Health Networks coordinate services when LEA services overlap with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

4. ***Policy MA.6044: Coverage of Solid Organ and Stem Cell Transplants*** defines the coverage of Solid Organ and Stem Cell Transplants and related care and services. The exclusion of procurement fees for kidney transplants from CalOptima or a Health Networks responsibility was added, which will be the responsibility of Original Medicare Fee for Service Program.

5. ***Policy MA.6101 Medicare Part D Coverage Determination*** This policy describes CalOptima's process for determination of drug benefit coverage and/or payment of drug benefits for Medicare Part D in accordance with standards established by the Centers for Medicare & Medicaid Services (CMS). The policy has been updated to reflect new guidance release for Parts C & D Enrollee Grievances, Organization/ Coverage Determinations, and Appeals Guidance, effective January 1, 2020.

Fiscal Impact
The recommended action to revise CalOptima Policies GG.1800, GG.1810, GG.1321, MA.6044, and MA.6101 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation
To ensure CalOptima's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, and rules, CalOptima staff recommends that the Board approve and adopt the presented CalOptima policies and procedures. The updated policies and procedures will supersede the prior version.

Concurrence
Gary Crockett, Chief Counsel

Back to Agenda

Attachments

1. Policy GG. 1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B) (Redlined and Clean versions)
2. Policy GG.1810: Bed Hold, Long-Term Care (Redlined and Clean versions)
3. Policy GG.1321: Coordination of Care for Local Education Agency Services (Redlined and Clean versions)
4. Policy MA.6044: Coverage of Solid Organ and Stem Cell Transplants (Redlined and Clean versions)
5. Policy MA.6101: Medicare Part D Coverage Determination (Redlined and Clean versions)
6. Centers for Medicare and Medicaid Services Final Rule

/s/ Richard Sanchez *10/28/2020*
Authorized Signature **Date**

Back to Agenda

Policy:	GG.1800
Title:	**Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)**
Department:	Medical Management
Section:	Long Term Services and Supports
Interim CEO Approval:	
Effective Date:	06/01/1998
Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

For 2020 1105 BOD Review Only

I. PURPOSE

This policy outlines the requirements for reviewing and processing Long-Term Care (LTC) ~~Authorizations~~authorizations for a Member's admission to, continued stay in, or discharge from a nursing facility under Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B~~).~~) levels of care.

II. POLICY

A. CalOptima's Long-Term Services and Supports (LTSS) Department shall process all requests for admission to, continued stay in, or discharge from a nursing facility under Nursing Facility ~~(NF)~~ Level A (NF-A) and~~/or~~ Nursing Facility Level B (NF-B) levels of care pursuant to the Department of Health Care Services (DHCS) standard clinical criteria in the Medi-Cal Manual of Criteria, Chapter 7, Criteria for Long-Term Care Services.

B. For initial admissions, a facility shall submit a completed Long-Term Care (LTC) Authorization Request Form (ARF) within twenty-one (21) calendar days from the start date of CalOptima LTC coverage along with all necessary supporting documentation to make a Medical Necessity determination. For re-authorizations of a continued stay, the facility shall also submit a completed LTC ARF along with all necessary documentation to justify continued stay at least twenty-four (24) hours prior to the expiration of the active LTC ARF.

1. If a facility submits an LTC ARF after required timeframe, but the LTC ARF meets the level of care requested, CalOptima shall subject the authorization to a fifteen percent (15%) payment reduction. The rate of reduction is established by CalOptima and shall be adjusted periodically, based on the LTC Facilities Annual Financial Reporting data from the California Office of Statewide Health Planning and Development (OSHPD).

C. CalOptima may decide, at its discretion, to perform an on-site level of care determination for an LTC ARF. This determination shall follow an in-person assessment of the Member and a thorough review of the medical orders, care plan, therapist treatment plan, the facility's multidisciplinary team notes, or other clinical data appropriate to support making the determination on the authorization request.

Back to Agenda Back to Item

D. If CalOptima's review of the medical records and/or in-person assessment of the Member determines the authorization request for NF-B level of care does not meet clinical criteria because indicated acuity and care needs were too low, the authorization request will be reviewed by CalOptima's Medical Director against NF-A level of care clinical criteria. If the Member in such cases was determined to meet NF-A criteria by the Medical Director, a Modified Approval would be issued along with all standard appeals rights.

E. CalOptima shall review authorizations for short stays in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

III. PROCEDURE

A. CalOptima shall utilize the DHCS standard clinical criteria in the LTC ARF adjudication process as stated in the Medi-Cal Manual of Criteria, Chapter 7: Criteria for Long Term Care Services.

~~A.~~B. For a non-contracted facility requesting authorization for services, CalOptima shall verify if the facility:

1. Is licensed by the California Department of Public Health (CDPH);

2. Meets acceptable quality standards; ~~and~~

3. Signed a Letter of Agreement in order to obtain reimbursement in accordance with CalOptima Policy EE.1135: Long-Term Care Facility Contracting; and

~~3.~~4. Agrees to CalOptima rates, in accordance with CalOptima Policy EE.1135: Long-~~-~~Term Care Facility Contracting.

~~B.~~C. A non-contracted facility shall provide the required documentation to CalOptima for Credentialing purposes~~.~~ as referenced in CalOptima Policy EE.1135: Long Term Care Facility Contracting and pursuant to CalOptima Policy GG.1651Λ: Credentialing and Recredentialing of Healthcare Delivery Organizations.

~~B. Services provided by any category for intermediate care facility for the developmentally disabled, including Intermediate Care Facility/Developmentally Disabled (ICF/DD), ICF/DD Habilitative (ICF/DD-H), or an ICF/DD Nursing (ICF/DD-N), shall be excluded from the OneCare Connect program. These services shall be covered through the CalOptima Medi-Cal benefit.~~

~~C.~~D. ~~A~~For initial admissions, a facility shall submit a completed Long-~~-~~Term Care (LTC) Authorization Request Form (ARF) (Sections I through ~~IV),~~V) with a physician's signature on the ARF or accompanied by a separate nursing facility long-term care order written by the physician, Minimum Data Set (MDS), ~~Provider Utilization Committee Determination (~~Medicare or other insurance denial~~)~~ letter as appropriate, and Preadmission Screening and Resident Review (PASRR) Screening Level I Document forms within twenty-one (21) calendar days from the start date of CalOptima LTC coverage.

~~1. If a facility submits an LTC ARF after the twenty-one (21) calendar day requirement, but the LTC ARF meets the level of care requested, CalOptima shall subject the LTC ARF to a fifteen percent (15%) payment reduction. The rate of reduction is established by CalOptima and shall be adjusted periodically, based on the LTC Facilities Annual Financial Reporting data from the California Office of Statewide Health Planning and Development (OSHPD).~~

For 2020 10-5 BOD Review Only

Back to Agenda Back to Item

~~C. CalOptima may decide, at its discretion, to perform an on-site level of care review of an LTC ARF. This review shall include an assessment of the Member and review of the medical orders, care plan, therapist treatment plan, the facility's multidisciplinary team notes, or other clinical data to assist CalOptima staff in making an appropriate determination on the authorization request.~~

~~D.~~E. ~~The facility shall submit a reauthorization of~~For re-authorizations of a continued stay, the facility shall submit an LTC ARF to the CalOptima LTSS Department at least twenty-four (24) hours prior to the expiration of the active LTC ARF. The facility may submit a reauthorization LTC ARF up to sixty (60) calendar days prior to the expiration of the active LTC ARF. The requests shall include a completed LTC ARF (Sections I, III [as applicable], and IV~~) signed by a physician,)~~, the most recent MDS Quarterly Assessment ~~MDS~~, and ~~sufficient~~adequate documentation to justify the level of care and continued stay.

~~D. CalOptima or a Health Network shall be responsible for ensuring the provision of a Member's medical needs, supports, and services throughout the post-discharge and transition to community-based care period. The discharge planning may include, but is not limited to:~~

~~1. Documentation of pre-admission, or baseline, status;~~

~~2. Initial set-up of services needed after discharge, including but not limited to medical care, medication, durable medical equipment, identification, and integration of community based LTSS programs;~~

~~3. Initial coordination of care, as appropriate with the Member's caregiver, other agencies and knowledgeable personnel, as well as ensuring the Member's care coordinator contact information for hospitals; and~~

~~4. Provision of information for making follow-up appointments.~~

~~CalOptima or a Health Network shall be responsible for ensuring that all Medically Necessary services are provided in a timely manner upon discharge, and that a Member's transition to the most appropriate level of care and community-based care occurs, from the SNF, that meets the Member's medical and social needs.~~

~~III. PROCEDURE~~

~~E.~~A. ~~CalOptima shall utilize the DHCS standard clinical criteria in the LTC ARF adjudication process as stated in the Medi-Cal Manual of Criteria, Chapter 7: Criteria for Long Term Care Services.~~

~~F. The LTC ARF request is initiated by the facility and must be signed by the attending physician.~~

F. The LTC authorization process is initiated by the facility with the presentation of a completed LTC ARF along with supporting clinical records. CalOptima LTSS Department shall approve, modify, or deny the facility's request in a timeframe that is appropriate for the Member's medical condition, but no longer than five (5) business days from CalOptima's receipt of all information requested that is reasonably necessary to make a determination.

G. If the LTC ARF and required documents are incomplete, the CalOptima LTSS Department shall ~~defer~~delay the approval process and return the incomplete LTC ARF and any attachments, if appropriate, to the facility for review and resubmission with additional clinical documents.

For 20201105 BOD Review Only

CalOptima LTSS Department will ~~send~~notify the facility ~~a "NOA Delay" letter~~ within twenty-four (24) hours of decision to delay~~.~~ determination due to insufficient clinical documents. When unable to make a determination, the CalOptima nurse case manager will document the need for additional information, what information is required, and that the facility will have fourteen (14) calendar days from the initial presentation of the ARF to provide the documents. The facility shall resubmit the LTC ARF ~~within~~before the end of the fourteen (14) calendar days after the submission of the initial LTC ARF or the LTC ARF shall be subject to denial.

H. ~~If CalOptima's LTSS Department is unable to approve the ARF due to insufficient documentation of Medical Necessity~~If the nursing facility is unable to provide the additional requested documents within the fourteen (14) calendar days for CalOptima to make a determination, the Member or the nursing facility staff can request a deferral to receive an additional fourteen (14) calendar days to collect the required documents. Such a deferral request must be received within the initial fourteen (14)-day period. The LTSS nurse case manager will initiate the process with a written Integrated Denial Notice/Notice of Action Delay letter that will be faxed to the nursing facility and mailed to the Member. After a total of twenty-eight (28) calendar days, if the additional records are still not presented, the CalOptima nurse case manager will make a determination based on only the available documentation at that time.

~~H.~~I. For Medical Necessity determinations, if the CalOptima LTSS Department is unable to approve the ARF due to insufficient documentation, the CalOptima LTSS Department shall submit the LTC ARF and accompanying documentation to the CalOptima Medical Director, or authorized physician designee, for review and determination.

1. If CalOptima's Medical Director, or physician designee, approves the LTC ARF, the CalOptima LTSS Department shall send ~~a~~an approval letter with the copy of the approved LTC ARF to the facility.

2. If CalOptima's Medical Director, or physician designee, denies or modifies the LTC ARF, the CalOptima LTSS Department shall notify the facility, the Member, or the Member's Authorized Representative in accordance with CalOptima Policies GG.1814: Appeals Process for Long Term Care Facility Daily Rate Denial and GG.1508: Authorization and Processing of Referrals.

~~I.~~J. If the facility ~~submits a complete LTC ARF~~submitted the completed LTC ARF and all necessary clinical records to support an approval within the twenty-one (21) calendar day submission period, CalOptima shall approve the LTC ARF ~~retroactive~~back to the date of the admission or the beginning of CalOptima coverage, whichever is later.

~~J.~~K. If the facility submits the LTC ARF and the necessary clinical records later than the twenty-one (21) calendar day submission period, and CalOptima approves the LTC ARF, CalOptima shall subject the LTC ARF to a fifteen percent (15%) payment reduction from the date of the Member's admission up to the date on which the CalOptima LTSS Department received the completed LTC ARF.

~~K.~~L. CalOptima LTSS shall provide ~~Members~~the Member and ~~Providers~~the facility with a written Integrated Denial Notice/Notice of Action, as appropriate, for any decisions to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. A written Integrated Denial Notice/Notice of Action will therefore also be provided for decisions to approve NF-B authorization requests at the NF-A level of care.

~~L.~~M. Upon receipt of an LTC ARF modification~~,~~ or denial, the Member and the facility shall ~~have the ability~~both be eligible to file an appeal~~, or complaint~~, in accordance with CalOptima Policies

For 2020 1105 BOD Review Only

Back to Agenda Back to Item

GG.1510: Appeal Process for Decisions Regarding Care and Services and GG.1814: Appeals Process for Long Term Care Facility Daily Rate Denial.

N. When appropriate, CalOptima or a Health Network shall assist nursing facility staff with coordination of services that can support a Member's safe discharge or transition to the community in accordance with CalOptima Policy GG.1822: Process for Transitioning CalOptima Members between Levels of Care.

~~M.~~O. Upon notification by a facility of a Member's discharge, the CalOptima LTSS Department shall close the active LTC ~~ARF~~authorization, effective the day of discharge. The facility shall notify CalOptima within one (1) business day of a Member's discharge by sending the Discharge Disposition Form to the LTSS Department and submitting a completed Medi-Cal LTC Facility Discharge Notification Form (MC171) to the appropriate agency. The CalOptima LTSS Department shall notify the appropriate departments and Health Network for further care coordination.

IV. ATTACHMENT(S)

A. CalOptima Long-~~-~~Term Care (LTC) Authorization Request Form (ARF)
B. Discharge Disposition Form

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy EE.1135: Long Term Care Facility Contracting
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services
E. CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations
F. CalOptima Policy GG.1802 Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H and ICF/DD-N
~~E.~~G. CalOptima Policy GG.1814: Appeals Process for Long Term Care Facility Daily Rate Denial
H. CalOptima Policy GG.1822: Process for Transitioning CalOptima Members between Levels of Care
~~F.~~I. CalOptima Provider Resource Manual
~~G.~~J. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~H.~~K. CalOptima Utilization Management Program
~~I.~~L. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and Your Rights
~~J. Department of Health Care Services Duals Plan Letter (DPL) 14-004: Continuity of Care~~
~~K. Department of Health Care Services Duals Plan Letter (DPL) 16-003: Discharge Planning for Cal MediConnect~~
~~L.~~M. Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division
~~M.~~N. Title 22, California Code of Regulations (CCR), §§ 51120, 51121, 51124, 51215, 51118 and 51212
~~N.~~O. Welfare and Institutions (W&I) Code, §§ 14087.55, 14087.6, 14087.9, and 14103.6

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/26/2016	Department of Health Care Services (DHCS)

For 2020 1105 BOD Review Only

VII. BOARD ACTION(S)

Date	Meeting
11/05/2002	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Title	Program(s)
Effective	06/01/1998	GG.1800	Authorization Request Form (ARF) Process and Criteria for Admission to, Continued Stay in, and Discharge from a Skilled Nursing Facility (SNF) or Intermediate Care Facility	Medi-Cal
Revised	03/01/2008	GG.1800	Authorization Request Form (ARF) Process and Criteria for Admission to, Continued Stay in, and Discharge from a Skilled Nursing Facility (SNF) or Intermediate Care Facility	Medi-Cal
Effective	07/01/2015	CMC.1800	Authorization Request Form (ARF) Process and Criteria for Admission to, Continued to Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	OneCare Connect
Revised	02/01/2016	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised	10/01/2016	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised	11/01/2017	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised	12/18/2018	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised		GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect

For 20201105 BOD Review Only

IX. GLOSSARY

Term	Definition
Authorized Representative	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations.~~ A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in *loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009~~:~~Δ: Access by a Member's Authorized Representative.
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to ~~Members~~members assigned to that ~~Health Network~~health network.
Integrated Denial Notice	For the purposes of this policy, a written notice of action of denial, reduction, or modification of services requested by ~~Members~~members enrolled in CalOptima's OneCare Connect program, consistent with applicable regulatory and contract requirements.
Medically Necessary/Medical Necessity	Medi-Cal: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. OneCare Connect: Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	An beneficiary enrolled in a CalOptima Program.
Notice of Action (NOA)	For the purposes of this policy, a written notice of action of denial, reduction, or modification of services requested by ~~Members~~members enrolled in the CalOptima Medi-Cal program, consistent with applicable regulatory and contract requirements.
Nursing Facility Level A (NF-A)	Level of care characterized by scheduled and predictable nursing needs with a need for protective and supportive care, but without the need for continuous, licensed nursing.
Nursing Facility Level B (NF-B)	Level of care characterized by an individual requiring the continuous availability of skilled nursing care provided by a licensed registered or vocational nurse yet does not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care.

For 2020 105 BOD Review Only

Back to Agenda Back to Item

Term	Definition
PASRR Level I Screening	A screening completed by a nursing facility for each resident that is going to be admitted to a Medicaid certified nursing facility. The purpose of the Level I screening is to identify a resident who has a mental illness or is suspected of having mental illness, an intellectual/developmental disability, or a related condition to determine if specialized services are needed during their stay in a nursing facility.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, ~~Health Network~~health network, physician group, or other person or institution who furnishes Covered Services.

1

For 20201105 BOD Review Only

Policy:	GG.1800
Title:	**Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)**
Department:	Medical Management
Section:	Long Term Services and Supports
Interim CEO Approval:	
Effective Date:	06/01/1998
Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

For 2020 1105 BOD Review Only

I. PURPOSE

This policy outlines the requirements for reviewing and processing Long-Term Care (LTC) authorizations for a Member's admission to, continued stay in, or discharge from a nursing facility under Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B) levels of care.

II. POLICY

A. CalOptima's Long-Term Services and Supports (LTSS) Department shall process all requests for admission to, continued stay in, or discharge from a nursing facility under Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B) levels of care pursuant to the Department of Health Care Services (DHCS) standard clinical criteria in the Medi-Cal Manual of Criteria, Chapter 7, Criteria for Long-Term Care Services.

B. For initial admissions, a facility shall submit a completed Long-Term Care (LTC) Authorization Request Form (ARF) within twenty-one (21) calendar days from the start date of CalOptima LTC coverage along with all necessary supporting documentation to make a Medical Necessity determination. For re-authorizations of a continued stay, the facility shall also submit a completed LTC ARF along with all necessary documentation to justify continued stay at least twenty-four (24) hours prior to the expiration of the active LTC ARF.

1. If a facility submits an LTC ARF after required timeframe, but the LTC ARF meets the level of care requested, CalOptima shall subject the authorization to a fifteen percent (15%) payment reduction. The rate of reduction is established by CalOptima and shall be adjusted periodically, based on the LTC Facilities Annual Financial Reporting data from the California Office of Statewide Health Planning and Development (OSHPD).

C. CalOptima may decide, at its discretion, to perform an on-site level of care determination for an LTC ARF. This determination shall follow an in-person assessment of the Member and a thorough review of the medical orders, care plan, therapist treatment plan, the facility's multidisciplinary team notes, or other clinical data appropriate to support making the determination on the authorization request.

Back to Agenda Back to Item

D. If CalOptima's review of the medical records and/or in-person assessment of the Member determines the authorization request for NF-B level of care does not meet clinical criteria because indicated acuity and care needs were too low, the authorization request will be reviewed by CalOptima's Medical Director against NF-A level of care clinical criteria. If the Member in such cases was determined to meet NF-A criteria by the Medical Director, a Modified Approval would be issued along with all standard appeals rights.

E. CalOptima shall review authorizations for short stays in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

III. PROCEDURE

A. CalOptima shall utilize the DHCS standard clinical criteria in the LTC ARF adjudication process as stated in the Medi-Cal Manual of Criteria, Chapter 7: Criteria for Long Term Care Services.

B. For a non-contracted facility requesting authorization for services, CalOptima shall verify if the facility:

1. Is licensed by the California Department of Public Health (CDPH);

2. Meets acceptable quality standards;

3. Signed a Letter of Agreement in order to obtain reimbursement in accordance with CalOptima Policy EE.1135: Long-Term Care Facility Contracting; and

4. Agrees to CalOptima rates, in accordance with CalOptima Policy EE.1135: Long-Term Care Facility Contracting.

C. A non-contracted facility shall provide the required documentation to CalOptima for Credentialing purposes as referenced in CalOptima Policy EE.1135: Long Term Care Facility Contracting and pursuant to CalOptima Policy GG.1651Λ: Credentialing and Recredentialing of Healthcare Delivery Organizations.

D. For initial admissions, a facility shall submit a completed Long-Term Care (LTC) Authorization Request Form (ARF) (Sections I through V) with a physician's signature on the ARF or accompanied by a separate nursing facility long-term care order written by the physician, Minimum Data Set (MDS), Medicare or other insurance denial letter as appropriate, and Preadmission Screening and Resident Review (PASRR) Screening Level I Document forms within twenty-one (21) calendar days from the start date of CalOptima LTC coverage.

E. For re-authorizations of a continued stay, the facility shall submit an LTC ARF to the CalOptima LTSS Department at least twenty-four (24) hours prior to the expiration of the active LTC ARF. The facility may submit a reauthorization LTC ARF up to sixty (60) calendar days prior to the expiration of the active LTC ARF. The requests shall include a completed LTC ARF (Sections I, III [as applicable], and IV), the most recent MDS Quarterly Assessment, and adequate documentation to justify the level of care and continued stay.

F. The LTC authorization process is initiated by the facility with the presentation of a completed LTC ARF along with supporting clinical records. CalOptima LTSS Department shall approve, modify, or deny the facility's request in a timeframe that is appropriate for the Member's medical condition, but no longer than five (5) business days from CalOptima's receipt of all information requested that is reasonably necessary to make a determination.

For 2020.10.7 BOD Review Only

Back to Agenda Back to Item

G. If the LTC ARF and required documents are incomplete, the CalOptima LTSS Department shall delay the approval process and return the incomplete LTC ARF and any attachments, if appropriate, to the facility for review and resubmission with additional clinical documents. CalOptima LTSS Department will notify the facility within twenty-four (24) hours of decision to delay determination due to insufficient clinical documents. When unable to make a determination, the CalOptima nurse case manager will document the need for additional information, what information is required, and that the facility will have fourteen (14) calendar days from the initial presentation of the ARF to provide the documents. The facility shall resubmit the LTC ARF before the end of the fourteen (14) calendar days after the submission of the initial LTC ARF or the LTC ARF shall be subject to denial.

H. If the nursing facility is unable to provide the additional requested documents within the fourteen (14) calendar days for CalOptima to make a determination, the Member or the nursing facility staff can request a deferral to receive an additional fourteen (14) calendar days to collect the required documents. Such a deferral request must be received within the initial fourteen (14)-day period. The LTSS nurse case manager will initiate the process with a written Integrated Denial Notice/Notice of Action Delay letter that will be faxed to the nursing facility and mailed to the Member. After a total of twenty-eight (28) calendar days, if the additional records are still not presented, the CalOptima nurse case manager will make a determination based on only the available documentation at that time.

I. For Medical Necessity determinations, if the CalOptima LTSS Department is unable to approve the ARF due to insufficient documentation, the CalOptima LTSS Department shall submit the LTC ARF and accompanying documentation to the CalOptima Medical Director, or authorized physician designee, for review and determination.

1. If CalOptima's Medical Director, or physician designee, approves the LTC ARF, the CalOptima LTSS Department shall send an approval letter with the copy of the approved LTC ARF to the facility.

2. If CalOptima's Medical Director, or physician designee, denies or modifies the LTC ARF, the CalOptima LTSS Department shall notify the facility, the Member, or the Member's Authorized Representative in accordance with CalOptima Policies GG.1814: Appeals Process for Long Term Care Facility Daily Rate Denial and GG.1508: Authorization and Processing of Referrals.

J. If the facility submitted the completed LTC ARF and all necessary clinical records to support an approval within the twenty-one (21) calendar day submission period, CalOptima shall approve the LTC ARF back to the date of the admission or the beginning of CalOptima coverage, whichever is later.

K. If the facility submits the LTC ARF and the necessary clinical records later than the twenty-one (21) calendar day submission period, and CalOptima approves the LTC ARF, CalOptima shall subject the LTC ARF to a fifteen percent (15%) payment reduction from the date of the Member's admission up to the date on which the CalOptima LTSS Department received the completed LTC ARF.

L. CalOptima LTSS shall provide the Member and the facility with a written Integrated Denial Notice/Notice of Action, as appropriate, for any decisions to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. A written Integrated Denial Notice/Notice of Action will therefore also be provided for decisions to approve NF-B authorization requests at the NF-A level of care.

For 20201105 BOD Review Only

M. Upon receipt of an LTC ARF modification or denial, the Member and the facility shall both be eligible to file an appeal, in accordance with CalOptima Policies GG.1510: Appeal Process for Decisions Regarding Care and Services and GG.1814: Appeals Process for Long Term Care Facility Daily Rate Denial.

N. When appropriate, CalOptima or a Health Network shall assist nursing facility staff with coordination of services that can support a Member's safe discharge or transition to the community in accordance with CalOptima Policy GG.1822: Process for Transitioning CalOptima Members between Levels of Care.

O. Upon notification by a facility of a Member's discharge, the CalOptima LTSS Department shall close the active LTC authorization, effective the day of discharge. The facility shall notify CalOptima within one (1) business day of a Member's discharge by sending the Discharge Disposition Form to the LTSS Department and submitting a completed Medi-Cal LTC Facility Discharge Notification Form (MC171) to the appropriate agency. The CalOptima LTSS Department shall notify the appropriate departments and Health Network for further care coordination.

IV. ATTACHMENT(S)

A. CalOptima Long-Term Care (LTC) Authorization Request Form (ARF)
B. Discharge Disposition Form

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy EE.1135: Long Term Care Facility Contracting
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services
E. CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations
F. CalOptima Policy GG.1802 Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H and ICF/DD-N
G. CalOptima Policy GG.1814: Appeals Process for Long Term Care Facility Daily Rate Denial
H. CalOptima Policy GG.1822: Process for Transitioning CalOptima Members between Levels of Care
I. CalOptima Provider Resource Manual
J. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
K. CalOptima Utilization Management Program
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and Your Rights
M. Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division
N. Title 22, California Code of Regulations (CCR), §§ 51120, 51121, 51124, 51215, 51118 and 51212
O. Welfare and Institutions (W&I) Code, §§ 14087.55, 14087.6, 14087.9, and 14103.6

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/26/2016	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

For 2020 1105 BOD Review Only

Date	Meeting
11/05/2002	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Title	Program(s)
Effective	06/01/1998	GG.1800	Authorization Request Form (ARF) Process and Criteria for Admission to, Continued Stay in, and Discharge from a Skilled Nursing Facility (SNF) or Intermediate Care Facility	Medi-Cal
Revised	03/01/2008	GG.1800	Authorization Request Form (ARF) Process and Criteria for Admission to, Continued Stay in, and Discharge from a Skilled Nursing Facility (SNF) or Intermediate Care Facility	Medi-Cal
Effective	07/01/2015	CMC.1800	Authorization Request Form (ARF) Process and Criteria for Admission to, Continued to Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	OneCare Connect
Revised	02/01/2016	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised	10/01/2016	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised	11/01/2017	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised	12/18/2018	GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised		GG.1800	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect

For 20201105 BOD Review Only

IX. GLOSSARY

Term	Definition
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in *loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009Δ: Access by a Member's Authorized Representative.
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to members assigned to that health network.
Integrated Denial Notice	For the purposes of this policy, a written notice of action of denial, reduction, or modification of services requested by members enrolled in CalOptima's OneCare Connect program, consistent with applicable regulatory and contract requirements.
Medically Necessary/Medical Necessity	Medi-Cal: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. OneCare Connect: Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	An beneficiary enrolled in a CalOptima Program.
Notice of Action (NOA)	For the purposes of this policy, a written notice of action of denial, reduction, or modification of services requested by members enrolled in the CalOptima Medi-Cal program, consistent with applicable regulatory and contract requirements.
Nursing Facility Level A (NF-A)	Level of care characterized by scheduled and predictable nursing needs with a need for protective and supportive care, but without the need for continuous, licensed nursing.
Nursing Facility Level B (NF-B)	Level of care characterized by an individual requiring the continuous availability of skilled nursing care provided by a licensed registered or vocational nurse yet does not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care.

For 2020 10/8 BOD Review Only

Back to Agenda Back to Item

Term	Definition
PASRR Level I Screening	A screening completed by a nursing facility for each resident that is going to be admitted to a Medicaid certified nursing facility. The purpose of the Level I screening is to identify a resident who has a mental illness or is suspected of having mental illness, an intellectual/developmental disability, or a related condition to determine if specialized services are needed during their stay in a nursing facility.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, health network, physician group, or other person or institution who furnishes Covered Services.

1

For 20201105 BOD Review Only

CalOptima
A Public Agency
Better. Together.

P.O. Box 11045
Orange, CA 92856
Phone No. 714-246-8444
Fax No. 714-246-8843

For CalOptima Use Only	*For CalOptima Use Only*
REFERENCE NO:	**Status:** ☐ Approved as Requested ☐ Pending
	From: **To:**

Long-Term Care Authorization Request Form (Admissions)

☐ Initial ☐ Re-Authorization ☐ Retroactive Eligibility
☐ Bed Hold/Leave of Absence ☐ Retro-Authorization ☐ Treatment in Place (CCN only)

SECTION I

Bed Hold Start Date: _____ Bed Hold End Date: _____
Bed Hold Start Date: _____ Bed Hold End Date: _____

Date of Admission: **Dates of Service Requested:** **From:** **To:**

PROVIDER: Authorization does not guarantee payment. CalOptima ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ (Last) _____ (First) ☐ M ☐ F **D.O.B.** _____ **Age:** _____

Mailing Address: _____ **City:** _____ **ZIP:** _____ **Phone:** _____

CIN#: _____ **Aid Code:** _____ **County Code:** _____

Facility Name:	**Physician Name:**
Facility Address: **City:** **ZIP:** **Phone:**	**Physician Address:** **City:** **ZIP:** **Phone:**
Fax Number:	**Fax Number:**
Medi-Cal Provider ID #/NPI:	**Physician Medi-Cal ID #:**
Former Facility: **Office Contact:**	**Physician Signature:**
Diagnosis:	**ICD - 10 Code:**

☐ **SNF** ☐ **ICF** ☐ **ICFDD** ☐ **ICFDDN** ☐ **ICFDDH** ☐ **SUBACUTE-VENT** ☐ **SUBACUTE-NON-VENT**

SECTION II Admitted From:

- ☐ Member's Home
- ☐ Household of Another
- ☐ Board & Care /Assisted Living
- ☐ Acute Hospital — Home, B&C Immediately prior to acute
- ☐ Acute Hospital — SNF/ICF Immediately prior to acute
- ☐ Another SNF/ICF

SECTION III

Date PASRR completed by NF: _____
Level II screening required: YES ☐ NO ☐
Date of referral: _____
Date Level II completed: _____
Pertinent Medications:

SECTION IV Patient's General Condition:

- ☐ Bedridden
- ☐ Ambulatory with Assistance
- ☐ Ambulatory
- ☐ Incontinent of B&B
- ☐ Confined to Wheelchair
- ☐ Maximum Assist with all ADLs

SECTION V

Community placement alternatives considered? YES ☐ NO ☐
If no, select all applicable boxes

- ☐ Community resources unavailable
- ☐ Due to, or change in medical, mental & physical functioning capability
- ☐ Caregiver unavailable
- ☐ Resident, conservator, or family choice
- ☐ Other

DO NOT WRITE BELOW THIS LINE **FOR CalOptima USE ONLY**

COMMENTS:

Signature: **Date:**

Long-Term Services & Supports (LTSS)
Long-Term Care (LTC)
Phone: 714-246-8444
Fax: 714-246-8843

Discharge Disposition Form

Nursing Facility Name			
Member Information	First Name:	Last Name:	
Admission Date:		Discharge/Expired Date:	☐ Expired?
Client Identification Number (CIN):		Date of Birth:	
Address: (Discharge Destination)			Phone Number:
Name of Physician(s):		LTC Authorization Number:	
Discharge Diagnoses	ICD-10 Code:	Description:	

IF EXPIRED, STOP HERE.

Discharge Plan

Most Recent Interdisciplinary Care Team (ICT) Meeting Date:			
Discharge Plan:			
Facility or Family Address Where Discharged:			
Selected Community PCP:	First Name:	Last Name:	
Phone:		NPI/PID from Provider Directory:	
Address:			

Discharge Reason/ Disposition (check all that apply)

- ☐ Discharged to acute hospital/higher level of care
- ☐ Discharged to another SNF/ICF/SA
- ☐ Discharged to residence/home of another
- ☐ Discharged to board and care
- ☐ Discharged to motel
- ☐ Ineligible with CalOptima
- ☐ Left Against Medical Advice (AMA)
- ☐ No longer needs nursing facility services
- ☐ Poses risk to the health or safety of individuals in the nursing facility
- ☐ Other (specify):

Nursing Facility Offered Member Home- and Community-Based Services (HCBS) (check all that apply)

- ☐ 2-1-1 Orange County
- ☐ Aging & Disability Resource Connection
- ☐ AIDS Services Foundation
- ☐ Alzheimer's Association
- ☐ Assisted Living
- ☐ Board and Care Facility
- ☐ Case Management (CM) Program
- ☐ Community-Based Adult Services (CBAS)
- ☐ Community Care Transition (CCT)
- ☐ Dental
- ☐ Food Stamps
- ☐ Genetically Handicapped Person's Program (GHPP)
- ☐ Hemophilia Program
- ☐ Health Insurance Counseling & Advocacy Program (HICAP)
- ☐ Hospice
- ☐ Independent Living System
- ☐ In-Home Operations
- ☐ In-Home Supportive Services (IHSS)
- ☐ Legal Aid Society
- ☐ Meals on Wheels/Food Resource
- ☐ Multipurpose Senior Services Program (MSSP)
- ☐ Orange County Housing
- ☐ Program of All-Inclusive Care for the Elderly (PACE)
- ☐ Regional Center of Orange County
- ☐ Shelter
- ☐ Transportation
- ☐ Waiver Program
- ☐ Other (specify):

Print Member/Representative Party Name:	Post Discharge Phone No.:
Facility Representative Signature:	Date:

Policy:	GG.1810
Title:	**Bed Hold, Long-Term Care**
Department:	Medical Management
Section:	Long-Term Services and Supports
CEO Approval:	
Effective Date:	06/01/1998
Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

For 20201105 BOD Review Only

I. PURPOSE

This policy defines the ~~terms by which~~process for LTC Bed Holds, including authorization review ~~shall be made~~ for Bed Hold days when a Member is transferred to a General Acute Care Hospital from a Long-Term Care (LTC) Facility, including a Nursing Facility Level A (NF-A), Nursing Facility Level B (NF-B), Subacute Facility-Adult, Subacute Facility-Pediatric, Intermediate Care Facility (ICF), Intermediate Care Facility-Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N), in accordance with the Member's ~~individual~~Individual Care Plan ~~of Care, and to ensure~~(ICP), Bed Hold request processing for Members ~~receive coordinated~~ admitted for skilled short stay services (nursing facility stays less than 90 days) without an approved LTC authorization, and care coordination across the continuum of services~~.~~ for Members.

II. POLICY

A. An LTC facility shall hold a bed vacant when requested by a Member or a Member's Authorized Representative, with a physician Bed Hold order, unless notified in writing by the attending physician that the Member requires more than seven (7) calendar days of General Acute Care Hospital services.

B. A Bed Hold for a Member transferred to a General Acute Care Hospital is limited to seven (7) calendar days per hospitalization.

1. The day of departure from the LTC facility shall be counted as one (1) day of Bed Hold.

2. The day of return to the LTC facility shall be counted as one (1) day of inpatient care.

C. The Member's attending physician must write a physician order for a discharge or transfer at the time a Member requires a discharge or transfer from an LTC facility to a General Acute Care Hospital and include an order for Bed Hold. The written order for Bed Hold on the electronic health record must match the ~~supported~~supporting document on paper health record. The date of Bed Hold must be the same as the admission date to a General Acute Care Hospital.

D. The LTC facility will hold the bed vacant during the Bed Hold period.

Back to Agenda Back to Item

E. If an LTC facility is holding a bed and is notified in writing by the attending physician that the Member requires more than seven (7) days of general acute hospital care, the LTC facility shall no longer be required to hold the bed and shall not bill CalOptima for any remaining Bed Hold days.

F. There are no limits to the number of Bed Hold episodes. However, the Member shall remain at the facility at least twenty-four (24) hours prior to the start of the next Bed Hold period.

G. CalOptima shall pay the LTC facility at the facility daily rate minus the cost of raw food for the Bed Hold days as established by the California Department of Health Care Services (DHCS).

H. CalOptima shall not pay for Bed Hold days when a Member is discharged from a facility that is receiving payment for Bed Hold within twenty-four (24) hours after the Member's return from an acute care hospital.

I. If a Member dies while hospitalized, the nursing facility shall terminate the Bed Hold and CalOptima shall not pay the facility for the Bed Hold for the day of death.

J. The LTC facility shall ~~present the onsite~~submit to CalOptima ~~nurse or send~~ the ~~authorization request~~ARF for Bed Hold reimbursement ~~to CalOptima Long Term Services and Supports (LTSS) within twenty-one (21) calendar days after~~:.

1. For members admitted for skilled short stay services without an approved LTC authorization, the LTC facility shall submit an LTC ARF to the ~~end of the Bed Hold~~LTSS Department.

2. For members with an approved LTC authorization, an LTC ARF is not required; the LTC facility shall submit a Bed Hold payment request to the CalOptima claims department.

~~J.~~K. If CalOptima LTSS staff receives an ~~authorization request~~ARF after twenty-one (21) calendar days following the end of the Bed Hold, CalOptima shall consider the authorization late and shall not reimburse the nursing facility for the Bed Hold. The fifteen percent (15%) payment reduction does not apply to Bed Hold requests.

~~K.~~L. Pursuant to the requirements of this Policy, the Bed Hold will be either approved or denied for the duration of the time frame.

~~L.~~M. The Bed Hold ends on the day the Member returns to the nursing facility, reimbursement becomes the responsibility of another payer, or the Member does not return before the eighth (8^{th}) day.

III. PROCEDURE

A. In order for the LTC facility to qualify for reimbursement for a Bed Hold, the Member's Medical Records maintained at the nursing facility must:

1. Indicate the name and the address of the intended destination;

2. Have a written physician's transfer and Bed Hold order;

3. Have a start and an end date; and

4. Show the physician's order on electronic health record matches the paper health record if the facility uses two types of health records.

For 20201105 BOD Review Only

B. Except as specified in Section III.D of this Policy, CalOptima shall not require an LTC facility to submit another LTC Authorization Request Form (ARF) for a Member with an active LTC ARF who returns to the facility on or before the seventh (7^{th}) day of Bed Hold.

C. If a CalOptima Member on Bed Hold returns to the nursing facility after the seventh (7th) day of the Bed Hold, the Member is considered a readmission. The nursing facility shall submit the LTC Disposition Form to CalOptima's LTSS department within one (1) business day of the Bed Hold discharge and complete a new ~~authorization request.~~ARF . The CalOptima LTSS department shall close the active LTC authorization.

D. The nursing facility shall follow admission procedures as set forth in CalOptima Policies GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B), GG.1802: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N, and GG.1803: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility-Adult/Pediatric.

E. To receive authorization for the Bed Hold request for a Member admitted for skilled short stay services (nursing facility stays less than 90 days) without an approved LTC authorization, the LTC facility shall submit the following information with the LTC ARF within twenty-one (21) calendar days after the end of the Bed Hold:

1. A completed LTC ARF with an 'X' placed in the box marked 'Bed Hold/LOA' with the dates of service for the Bed Hold request;

2. A copy of the physician's order to transfer the Member to the General Acute Care Hospital and Bed Hold order written at the time of transfer;

3. The Member or Member's Authorized Representative request for Bed Hold; and

4. Nurse's notes or other clinical documentation as requested by LTSS staff to validate Member's status at the time of the transfer to General Acute Care Hospital.

F. An LTC Bed Hold (BH) ARF is not required for a Member residing in LTC nursing facility with an approved LTC ARF prior to acute hospital admission/transfer.

1. The LTC nursing facility will submit a Bed Hold payment request to the CalOptima Claims Department with appropriate Bed Hold accommodation codes for LTC level of care and Bed Hold dates of service.

IV. ATTACHMENT(S)

A. CalOptima Long-Term Care Authorization Request Form (LTC ARF)
B. CalOptima Discharge Disposition Form

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B).
C. CalOptima Policy GG.1802: ARF Process and Criteria for Admission to, Continued Stay in, or Discharge from an ICF/DD, ICF/DD-H and ICF/DD-N

For 2020105 BOD Review only

D. CalOptima Policy GG.1803: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility-Adult/Pediatric
E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-004: Medical Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
G. Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 14-002: Requirements for Nursing Facility Services.
H. Department of Health Care Services (DHCS): Medi-Cal Long Term Care Provider Manual
I. Health and Safety Code, §1250(a)
J. Title 22, California Code of Regulations (CCR), §§ 51121, 51212, 51215, 51215.5, 51215.8, 51335(b)(3), 51535.0, 72520, 73504,76079, 76345, 76853

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
07/16/2015	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1998	GG.1810	Bed Hold, Long Term Care	Medi-Cal
Revised	07/15/1998	GG.1810	Bed Hold, Long Term Care	Medi-Cal
Revised	02/01/2007	GG.1810	Bed Hold, Long Term Care	Medi-Cal
Revised	07/01/2015	GG.1810Δ	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	12/01/2015	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Correction	06/14/2016	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	12/01/2016	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	12/01/2017	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	12/05/2019	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	TBD	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect

For 20201105 BOD Review Only

IX. GLOSSARY

Term	Definition
Authorized Representative	Medi-Cal: A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors ~~and as further described in CalOptima Policy HH.3009: Access by a Member's Authorized Representative.~~. OneCare Connect: An individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the Appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423, Subpart M, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the Appeals process, subject to the rules described in Part 422, Subpart M.
Bed Hold	For the purposes of this policy, means when a Member is transferred from a Skilled Nursing Facility (SNF), including Subacute Facility, or Intermediate Care Facility (ICF) to a general acute care hospital and while hospitalized the facility holds the bed for up to seven (7) days until the Member returns to the same facility, as defined by Title 22, section 72520 and 73504.
General Acute Care Hospital	For the purposes of this policy, means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides twenty-four (24) hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services, per Health and Safety code, Section 1250 (a).
Individual Care Plan (ICP)	A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.
Intermediate Care Facility (ICF)	A health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.
Intermediate Care Facility/DD (Developmentally Disabled)	A facility that provides 24-hour personal care, habilitation, developmental, and support health services to developmentally disabled clients whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.
Intermediate Care Facility/DD-H (Habilitative)	A facility with a capacity of 4 to 15 beds that provide 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer developmentally disabled persons who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.

For 2/2016 BOD Review Only

Term	Definition
Intermediate Care Facility/DD-N (Nursing)	A facility with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for developmentally disabled persons who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated.
Medical Record	Any single, complete record kept or required to be kept by any provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	A beneficiary enrolled in a CalOptima Program.
Nursing Facility Level A (NF-A)	Known as the Intermediate Care Level. NF-A level of care is characterized by scheduled and predictable nursing needs with a need for protective and supportive care, but without the need for continuous, licensed nursing.
Nursing Facility Level B (NF-B)	Known as the Long-Term Care Nursing Facility level. NF-B level of care is characterized by an individual requiring the continuous availability of skilled nursing care provided by a licensed registered or vocational nurse, yet does not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care.
~~Plan of Care~~	~~An individual written plan of care completed, approved, and signed by a Physician and maintained in the member's medical records according to Title 42, Code of Federal Regulations (CFR).~~
Skilled Nursing Facility (SNF)	Medi-Cal: Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section 51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR, Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program. OneCare Connect: A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
Subacute Facility-Adult	A health facility that meets the standards set forth in Title 22, Section 51215.5, as an identifiable unit of a SNF accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DPH for such purpose and has been certified by the DHCS for participation in the Medi-Cal program.
Subacute Facility-Pediatric	A health facility that meets the standards set forth in Title 22, Section 51215.8, as an identifiable unit of a certified nursing facility licensed as a SNF meeting the standards for participation as a provider under the Medi-Cal program, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DHCS for such purpose.

For 2020 10-8 BOD Review Only

Policy:	GG.1810
Title:	**Bed Hold, Long-Term Care**
Department:	Medical Management
Section:	Long-Term Services and Supports
CEO Approval:	
Effective Date:	06/01/1998
Revised Date:	

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

For 20201105 BOD Preview Only

I. PURPOSE

This policy defines the process for LTC Bed Holds, including authorization review for Bed Hold days when a Member is transferred to a General Acute Care Hospital from a Long-Term Care (LTC) Facility, including a Nursing Facility Level A (NF-A), Nursing Facility Level B (NF-B), Subacute Facility-Adult, Subacute Facility-Pediatric, Intermediate Care Facility (ICF), Intermediate Care Facility-Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N), in accordance with the Member's Individual Care Plan (ICP), Bed Hold request processing for Members admitted for skilled short stay services (nursing facility stays less than 90 days) without an approved LTC authorization, and care coordination across the continuum of services for Members.

II. POLICY

A. An LTC facility shall hold a bed vacant when requested by a Member or a Member's Authorized Representative, with a physician Bed Hold order, unless notified in writing by the attending physician that the Member requires more than seven (7) calendar days of General Acute Care Hospital services.

B. A Bed Hold for a Member transferred to a General Acute Care Hospital is limited to seven (7) calendar days per hospitalization.

1. The day of departure from the LTC facility shall be counted as one (1) day of Bed Hold.

2. The day of return to the LTC facility shall be counted as one (1) day of inpatient care.

C. The Member's attending physician must write a physician order for a discharge or transfer at the time a Member requires a discharge or transfer from an LTC facility to a General Acute Care Hospital and include an order for Bed Hold. The written order for Bed Hold on the electronic health record must match the supporting document on paper health record. The date of Bed Hold must be the same as the admission date to a General Acute Care Hospital.

D. The LTC facility will hold the bed vacant during the Bed Hold period.

Back to Agenda Back to Item

E. If an LTC facility is holding a bed and is notified in writing by the attending physician that the Member requires more than seven (7) days of general acute hospital care, the LTC facility shall no longer be required to hold the bed and shall not bill CalOptima for any remaining Bed Hold days.

F. There are no limits to the number of Bed Hold episodes. However, the Member shall remain at the facility at least twenty-four (24) hours prior to the start of the next Bed Hold period.

G. CalOptima shall pay the LTC facility at the facility daily rate minus the cost of raw food for the Bed Hold days as established by the California Department of Health Care Services (DHCS).

H. CalOptima shall not pay for Bed Hold days when a Member is discharged from a facility that is receiving payment for Bed Hold within twenty-four (24) hours after the Member's return from an acute care hospital.

I. If a Member dies while hospitalized, the nursing facility shall terminate the Bed Hold and CalOptima shall not pay the facility for the Bed Hold for the day of death.

J. The LTC facility shall submit to CalOptima the ARF for Bed Hold reimbursement:.

1. For members admitted for skilled short stay services without an approved LTC authorization, the LTC facility shall submit an LTC ARF to the LTSS Department.

2. For members with an approved LTC authorization, an LTC ARF is not required; the LTC facility shall submit a Bed Hold payment request to the CalOptima claims department.

K. If CalOptima LTSS staff receives an ARF after twenty-one (21) calendar days following the end of the Bed Hold, CalOptima shall consider the authorization late and shall not reimburse the nursing facility for the Bed Hold. The fifteen percent (15%) payment reduction does not apply to Bed Hold requests.

L. Pursuant to the requirements of this Policy, the Bed Hold will be either approved or denied for the duration of the time frame.

M. The Bed Hold ends on the day the Member returns to the nursing facility, reimbursement becomes the responsibility of another payer, or the Member does not return before the eighth (8^{th}) day.

III. PROCEDURE

A. In order for the LTC facility to qualify for reimbursement for a Bed Hold, the Member's Medical Records maintained at the nursing facility must:

1. Indicate the name and the address of the intended destination;

2. Have a written physician's transfer and Bed Hold order;

3. Have a start and an end date; and

4. Show the physician's order on electronic health record matches the paper health record if the facility uses two types of health records.

B. Except as specified in Section III.D of this Policy, CalOptima shall not require an LTC facility to submit another LTC Authorization Request Form (ARF) for a Member with an active LTC ARF who returns to the facility on or before the seventh (7^{th}) day of Bed Hold.

For 20201105 BOD Review Only

C. If a CalOptima Member on Bed Hold returns to the nursing facility after the seventh (7th) day of the Bed Hold, the Member is considered a readmission. The nursing facility shall submit the LTC Disposition Form to CalOptima's LTSS department within one (1) business day of the Bed Hold discharge and complete a new ARF . The CalOptima LTSS department shall close the active LTC authorization.

D. The nursing facility shall follow admission procedures as set forth in CalOptima Policies GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B), GG.1802: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N, and GG.1803: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility-Adult/Pediatric.

E. To receive authorization for the Bed Hold request for a Member admitted for skilled short stay services (nursing facility stays less than 90 days) without an approved LTC authorization, the LTC facility shall submit the following information with the LTC ARF within twenty-one (21) calendar days after the end of the Bed Hold:

1. A completed LTC ARF with an 'X' placed in the box marked 'Bed Hold/LOA' with the dates of service for the Bed Hold request;

2. A copy of the physician's order to transfer the Member to the General Acute Care Hospital and Bed Hold order written at the time of transfer;

3. The Member or Member's Authorized Representative request for Bed Hold; and

4. Nurse's notes or other clinical documentation as requested by LTSS staff to validate Member's status at the time of the transfer to General Acute Care Hospital.

F. An LTC Bed Hold (BH) ARF is not required for a Member residing in LTC nursing facility with an approved LTC-ARF prior to acute hospital admission/transfer.

1. The LTC nursing facility will submit a Bed Hold payment request to the CalOptima Claims Department with appropriate Bed Hold accommodation codes for LTC level of care and Bed Hold dates of service.

IV. ATTACHMENT(S)

A. CalOptima Long-Term Care Authorization Request Form (LTC ARF)
B. CalOptima Discharge Disposition Form

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B).
C. CalOptima Policy GG.1802: ARF Process and Criteria for Admission to, Continued Stay in, or Discharge from an ICF/DD, ICF/DD-H and ICF/DD-N
D. CalOptima Policy GG.1803: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility-Adult/Pediatric
E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

For 2020 105 BOD Review Only

F. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-004: Medical Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
G. Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 14-002: Requirements for Nursing Facility Services.
H. Department of Health Care Services (DHCS): Medi-Cal Long Term Care Provider Manual
I. Health and Safety Code, §1250(a)
J. Title 22, California Code of Regulations (CCR), §§ 51121, 51212, 51215, 51215.5, 51215.8, 51335(b)(3), 51535.0, 72520, 73504,76079, 76345, 76853

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
07/16/2015	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1998	GG.1810	Bed Hold, Long Term Care	Medi-Cal
Revised	07/15/1998	GG.1810	Bed Hold, Long Term Care	Medi-Cal
Revised	02/01/2007	GG.1810	Bed Hold, Long Term Care	Medi-Cal
Revised	07/01/2015	GG.1810Δ	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	12/01/2015	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Correction	06/14/2016	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	12/01/2016	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	12/01/2017	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	12/05/2019	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	TBD	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect

For 20201105 BOD Review Only

IX. GLOSSARY

Term	Definition
Authorized Representative	Medi-Cal: A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors. OneCare Connect: An individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the Appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423, Subpart M, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the Appeals process, subject to the rules described in Part 422, Subpart M.
Bed Hold	For the purposes of this policy, means when a Member is transferred from a Skilled Nursing Facility (SNF), including Subacute Facility, or Intermediate Care Facility (ICF) to a general acute care hospital and while hospitalized the facility holds the bed for up to seven (7) days until the Member returns to the same facility, as defined by Title 22, section 72520 and 73504.
General Acute Care Hospital	For the purposes of this policy, means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides twenty-four (24) hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services, per Health and Safety code, Section 1250 (a).
Individual Care Plan (ICP)	A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.
Intermediate Care Facility (ICF)	A health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.
Intermediate Care Facility/DD (Developmentally Disabled)	A facility that provides 24-hour personal care, habilitation, developmental, and support health services to developmentally disabled clients whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.
Intermediate Care Facility/DD-H (Habilitative)	A facility with a capacity of 4 to 15 beds that provide 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer developmentally disabled persons who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.
Intermediate Care Facility/DD-N (Nursing)	A facility with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for developmentally disabled persons who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated.

For 20201105 POD Review Only

Term	Definition
Medical Record	Any single, complete record kept or required to be kept by any provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	A beneficiary enrolled in a CalOptima Program.
Nursing Facility Level A (NF-A)	Known as the Intermediate Care Level. NF-A level of care is characterized by scheduled and predictable nursing needs with a need for protective and supportive care, but without the need for continuous, licensed nursing.
Nursing Facility Level B (NF-B)	Known as the Long-Term Care Nursing Facility level. NF-B level of care is characterized by an individual requiring the continuous availability of skilled nursing care provided by a licensed registered or vocational nurse, yet does not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care.
Skilled Nursing Facility (SNF)	Medi-Cal: Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section 51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR, Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program. OneCare Connect: A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
Subacute Facility-Adult	A health facility that meets the standards set forth in Title 22, Section 51215.5, as an identifiable unit of a SNF accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DPH for such purpose and has been certified by the DHCS for participation in the Medi-Cal program.
Subacute Facility-Pediatric	A health facility that meets the standards set forth in Title 22, Section 51215.8, as an identifiable unit of a certified nursing facility licensed as a SNF meeting the standards for participation as a provider under the Medi-Cal program, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DHCS for such purpose.

1

For 2020 105 BOD Review Only

CalOptima
A Public Agency
Better. Together.

P.O. Box 11045
Orange, CA 92856
Phone No. 714-246-8444
Fax No. 714-246-8843

For CalOptima Use Only	*For CalOptima Use Only*
REFERENCE NO:	**Status:** ☐ Approved as Requested ☐ Pending
	From: **To:**

Long-Term Care Authorization Request Form (Admissions)

☐ Initial ☐ Re-Authorization ☐ Retroactive Eligibility
☐ Bed Hold/Leave of Absence ☐ Retro-Authorization ☐ Treatment in Place (CCN only)

SECTION I

Bed Hold Start Date: _____ Bed Hold End Date: _____
Bed Hold Start Date: _____ Bed Hold End Date: _____

Date of Admission: **Dates of Service Requested:** **From:** **To:**

PROVIDER: Authorization does not guarantee payment. CalOptima ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ (Last) _____ (First) ☐ M ☐ F **D.O.B.** _____ **Age:** _____

Mailing Address: _____ **City:** _____ **ZIP:** _____ **Phone:** _____

CIN#: _____ **Aid Code:** _____ **County Code:** _____

Facility Name:	**Physician Name:**
Facility Address: **City:** **ZIP:** **Phone:**	**Physician Address:** **City:** **ZIP:** **Phone:**
Fax Number:	**Fax Number:**
Medi-Cal Provider ID #/NPI:	**Physician Medi-Cal ID #:**
Former Facility: **Office Contact:**	**Physician Signature:**
Diagnosis:	**ICD - 10 Code:**

☐ **SNF** ☐ **ICF** ☐ **ICFDD** ☐ **ICFDDN** ☐ **ICFDDH** ☐ **SUBACUTE-VENT** ☐ **SUBACUTE-NON-VENT**

SECTION II Admitted From:

- ☐ Member's Home
- ☐ Household of Another
- ☐ Board & Care /Assisted Living
- ☐ Acute Hospital — Home, B&C Immediately prior to acute
- ☐ Acute Hospital — SNF/ICF Immediately prior to acute
- ☐ Another SNF/ICF

SECTION III

Date PASRR completed by NF: _____
Level II screening required: YES ☐ NO ☐
Date of referral: _____
Date Level II completed: _____
Pertinent Medications:

SECTION IV Patient's General Condition:

- ☐ Bedridden
- ☐ Ambulatory with Assistance
- ☐ Ambulatory
- ☐ Incontinent of B&B
- ☐ Confined to Wheelchair
- ☐ Maximum Assist with all ADLs

SECTION V

Community placement alternatives considered? YES ☐ NO ☐
If no, select all applicable boxes

- ☐ Community resources unavailable
- ☐ Due to, or change in medical, mental & physical functioning capability
- ☐ Caregiver unavailable
- ☐ Resident, conservator, or family choice
- ☐ Other

DO NOT WRITE BELOW THIS LINE **FOR CalOptima USE ONLY**

COMMENTS:

Signature: **Date:**

Long-Term Services & Supports (LTSS)
Long-Term Care (LTC)
Phone: 714-246-8444
Fax: 714-246-8843

Discharge Disposition Form

Nursing Facility Name			
Member Information	First Name:	Last Name:	
Admission Date:		Discharge/Expired Date:	☐ Expired?
Client Identification Number (CIN):		Date of Birth:	
Address: (Discharge Destination)			Phone Number:
Name of Physician(s):		LTC Authorization Number:	
Discharge Diagnoses	ICD-10 Code:	Description:	

IF EXPIRED, STOP HERE.

Discharge Plan

Most Recent Interdisciplinary Care Team (ICT) Meeting Date:			
Discharge Plan:			
Facility or Family Address Where Discharged:			
Selected Community PCP:	First Name:	Last Name:	
Phone:		NPI/PID from Provider Directory:	
Address:			

Discharge Reason/ Disposition (check all that apply)

- ☐ Discharged to acute hospital/higher level of care
- ☐ Discharged to another SNF/ICF/SA
- ☐ Discharged to residence/home of another
- ☐ Discharged to board and care
- ☐ Discharged to motel
- ☐ Ineligible with CalOptima
- ☐ Left Against Medical Advice (AMA)
- ☐ No longer needs nursing facility services
- ☐ Poses risk to the health or safety of individuals in the nursing facility
- ☐ Other (specify):

Nursing Facility Offered Member Home- and Community-Based Services (HCBS) (check all that apply)

- ☐ 2-1-1 Orange County
- ☐ Aging & Disability Resource Connection
- ☐ AIDS Services Foundation
- ☐ Alzheimer's Association
- ☐ Assisted Living
- ☐ Board and Care Facility
- ☐ Case Management (CM) Program
- ☐ Community-Based Adult Services (CBAS)
- ☐ Community Care Transition (CCT)
- ☐ Dental
- ☐ Food Stamps
- ☐ Genetically Handicapped Person's Program (GHPP)
- ☐ Hemophilia Program
- ☐ Health Insurance Counseling & Advocacy Program (HICAP)
- ☐ Hospice
- ☐ Independent Living System
- ☐ In-Home Operations
- ☐ In-Home Supportive Services (IHSS)
- ☐ Legal Aid Society
- ☐ Meals on Wheels/Food Resource
- ☐ Multipurpose Senior Services Program (MSSP)
- ☐ Orange County Housing
- ☐ Program of All-Inclusive Care for the Elderly (PACE)
- ☐ Regional Center of Orange County
- ☐ Shelter
- ☐ Transportation
- ☐ Waiver Program
- ☐ Other (specify):

Print Member/Representative Party Name:	Post Discharge Phone No.:
Facility Representative Signature:	Date:

Policy ~~#~~:	GG.1321
Title:	**Coordination of Care for Local Education Agency Services**
Department:	Medical ~~Affairs~~Management
Section:	Utilization Management
CEO Approval:	
Effective Date:	01/01/2009
~~Last Review Date:~~	~~07/01/18~~
~~Last~~ Revised Date:	~~07/01/18~~
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the guidelines for coordination of care by CalOptima or a Health Network for a Member who is eligible for services from a Local Education Agency (LEA).

II. POLICY

A. A Local Education Agency (LEA) provides certain Medically Necessary preventive, diagnostic, therapeutic, and rehabilitative services to eligible Members age three (3) years and older who are identified as Children with Special Health Care Needs (CSHCN~~).~~) while school is in session.

B. A Member may receive LEA services from his or her LEA in accordance with the Member's Individualized Education Plan (IEP) or Individual Family Service Plan (IFSP).

C. A Member may receive an IEP or IFSP from his or her LEA in accordance with applicable state and federal regulations.

D. LEA educational support services may include, but are not limited to, the following, when identified on the Member's IEP or IFSP:

1. Health and mental health evaluation;

a. Health and nutritional assessment and education;

b. Developmental assessment;

c. Vision assessment;

d. Hearing assessment

e. Education and psychosocial assessment;

f. Psychological and counseling services;

g. Nursing services;

For 20201105 BOD Review Only

Back to Agenda Back to Item

h. School aid health services;

i. Specialized medical transportation services and the associated mileage; and

j. Therapy services.

E. CalOptima, a Health Network, LEA practitioner (e.g., school nurse), or the Member's Primary Care Practitioner (PCP) shall identify a Member eligible for LEA services, as specified in Section III.B.1. of this Policy.

F. ~~-~~Upon appropriate identification of a Member eligible for LEA services, CalOptima, a Health Network, or the Member's PCP, shall refer the Member to his or her LEA.

G. A Member's PCP shall collaborate with CalOptima~~,~~ or a Health Network~~,~~ and the LEA to coordinate the provision of Medically Necessary services identified on the Member's IEP~~,~~ or IFSP.

H. The LEA must provide education to community providers and families on IEPs, as well as when LEA services, as opposed to health plan services, should be requested.

I. CalOptima and its Health Networks are not responsible for the provision, or payment, of LEA services, except as specified in Section III.A.1-2 of this Policy. CalOptima and its Health Networks shall provide Medically Necessary Covered Services that are not available under the LEA.

1. Services available through an LEA are not Covered Services under CalOptima's contract with the Department of Health Care Services. Therefore, if a Member's parents exercise their right to opt out of LEA services, such services will not be covered and paid for by CalOptima or its Health Networks in lieu of otherwise available LEA services, which are paid for by the State.

J. Whenever the LEA services overlap with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, CalOptima and its Health Networks shall:

1. Assess what level of EPSDT Medically Necessary services the Member requires.

2. Determine what level of service (if any) is being provided by the LEA.

3. Coordinate the provision of services with the other entities, such as CalOptima and its Health Networks, to ensure such entities are not providing duplicative services, and that the child is receiving all Medically Necessary EPSDT services in a timely manner.

K. CalOptima and its Health Networks have the primary responsibility to provide all Medically Necessary EPSDT services, including services which exceed the amount provided by the LEA.

1. An LEA will never be considered the primary provider of Medically Necessary EPSDT services, as this is the responsibility of CalOptima and its Health Networks.

III. PROCEDURE

A. CalOptima or a Health Network shall ensure coordination of care and provision of Medically Necessary Covered Services identified on a Member's IEP~~,~~ or IFSP.

1. ~~Children~~In order to ensure timely provision of Medically Necessary Covered Services, for children without an IEP and who have not previously received LEA physical therapy (PT), occupational therapy (OT), or speech therapy (ST) services, will receive an initial, six (6)-

For 20201105 BOD Review Only

Back to Agenda Back to Item

month authorization for requested LEA services based on a Medical Necessity determination. ~~A~~After the initial six (6)-month authorization, a denial from the Member's LEA for LEA services is required prior to CalOptima's authorizing ongoing services beyond the initial six (6)-month authorization period.

2. CalOptima shall provide LEA services, PT/OT/ST for continuation while school is not in session during hiatus/vacation periods when services cannot be provided by the LEA.

3. CalOptima shall not furnish services during the operative period of the LEA (i.e., the school year) if the services can be provided by the LEA.

B. A Member's PCP shall:

1. Identify a Member eligible for LEA services through:

a. Pediatric prevention screening;

b. Developmental screening;

c. Case management referrals;

d. Utilization Management (UM) referrals;

e. Parental referrals; and

f. Community referrals, such as the Regional Center of Orange County (RCOC);

2. Refer the Member to his or her LEA, upon appropriate identification;

3. Transfer the Member's Medical Records to the LEA in a timely manner, when requested, in accordance with CalOptima Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities.

4. Collaborate with the LEA in the development of the IEP, or IFSP, for a Member;

5. Coordinate the provision of Medically Necessary Covered Services with CalOptima, or the Member's Health Network, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals; and

6. Coordinate LEA services for a Member.

C. Notwithstanding a Member's eligibility for or receipt of LEA services, a Member's PCP shall function as a Medical Home, providing all appropriate screening, preventive, assessment, treatment planning, and coordination of Medically Necessary services in accordance with CalOptima Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

~~A. California Education Code, §§56032, 56340 et seq.~~

For 20201105 BOD Review Only

~~B.~~A. ~~California Government Code, §95020~~
~~C.~~A. CalOptima Contract for Health Care Services
~~D.~~B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~E.~~C. CalOptima Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
~~F.~~D. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~G.~~E. Department of Health Care Services ~~(DHCS)~~ Policy Letter (PL) 00-06: Managed Care Plan Relationships with Local Education Agency Providers
F. Department of Health Care Services All Plan Letter (APL) 19-010: Requirements for Coverage of EPSDT Services for Members Under Age 21
G. California Education Code, §§56032, 56340 et seq.
H. California Government Code, §95020
~~H.~~I. Welfare and Institutions Code §14132.06(h)
~~I.~~J. Title 22, California Code of Regulations, §§51096, 51309, 51323, 51360, 51190.1 through 51190.4, and 51535.5
~~J.~~K. Title 34, Code of Federal Regulations (CFR.) §300.323(c)
~~K.~~L. Title 35, Code of Federal Regulations (CFR.), §300.34
~~L.~~M. Title 42, Code of Federal Regulations (CFR.), §§431.53 and 440.130

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
10/31/17	Department of Health Care Services
01/13/16	Department of Health Care Services
09/23/20	Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2009	GG.1321	Coordination of Care for Local Education Agency Services	Medi-Cal
Revised	11/01/2015	GG.1321	Coordination of Care for Local Education Agency Services	Medi-Cal
Revised	01/01/2017	GG.1321	Coordination of Care for Local Education Agency Services	Medi-Cal
Revised	06/01/2017	GG.1321	Coordination of Care for Local Education Agency Services	Medi-Cal
Revised	07/01/2018	GG.1321	Coordination of Care for Local Education Agency Services	Medi-Cal
Revised		GG.1321	Coordination of Care for Local Education Agency Services	Medi-Cal

For 20201105 BOD Review Only

IX. GLOSSARY

Term	Definition
CalOptima	For purposes of this policy, CalOptima means CalOptima Direct and CalOptima Community Network (CCN).
Children with Special Health Care Needs (CSHCN)	Children who have or are at increased risk for chronic physical, behavioral, developmental, or emotional conditions, and who also require health care or related services of a type or amount beyond that required by children generally. The identification, assessment, treatment, and coordination of care for CSHCN shall comply with the requirements of Title 42, CFR, Sections 438.208(b)(3) and (b)(4), and 438.208(c)(2), (c)(3), and (c)(4).
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.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	A comprehensive and preventive child health program for individuals under the age of twenty-one (21) years. EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.
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.
Individual Family Service Plan (IFSP)	A written plan for providing early intervention services to a child eligible under the Individual with Disability Education Act (IDEA) and the child's family. The IFSP enables the family and service provider(s) to work together as equal partners in determining the early intervention services that are required for the child with disabilities and the family.
Individualized Education Plan (IEP)	A written document for an individual with exceptional needs that is developed, reviewed, and revised in a meeting in accordance with Sections 300.320 to 300.328, inclusive, of Title 34 of the Code of Federal Regulations and California Education Code, Title 2, Division 4, Part 30. It also means "individualized family service plan" as described in Section 1436 of Title 20 of the United States Code if the individualized education program pertains to an individual with exceptional needs younger than three (3) years of age.
Local Education Agency (LEA)	The governing body of any school district or community college district, county office of education, a charter school, a state special school, a California State University campus, or a University of California campus.

For 2020 105 ROD Review Only

Term	Definition
Medical Home	A place where a Member's medical information is maintained, and care is accessible, continuous, comprehensive and culturally competent. A Medical Home shall include, at a minimum: a Primary Care Physician (PCP) who provides continuous and comprehensive care; a physician-directed medical practice where the PCP leads a team of individuals who collectively take responsibility for the ongoing care of a Member; whole person orientation, where the PCP is responsible for providing all of the Member's health care needs or appropriately coordinating care; optimization and accountability for quality and safety by the use of evidence-based medicine, decision support tools, and continuous quality improvement; ready access to assure timely preventive, acute, and chronic illness treatment in the appropriate setting; and payment which is structured based on the value of the patient-centered ~~medical home~~Medical Home, and to support case management, coordination of care, enhanced communication, access and quality measurement services.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).~~.~~ –For EPSDT population, state and federal law define a service as "medically necessary" if the service is necessary to correct or ameliorate defects and physical and/or mental illnesses and conditions. A BHT service need not cure a condition in order to be covered. Services that maintain or improve the child's current health condition are considered a clinical benefit and must be covered.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the ~~medical home~~Medical Home for Members.

1

For 2020 IGT POD Review Only

Policy: GG.1321
Title: **Coordination of Care for Local Education Agency Services**
Department: Medical Management
Section: Utilization Management

CEO Approval:

Effective Date: 01/01/2009
Revised Date:

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

I. PURPOSE

This policy defines the guidelines for coordination of care by CalOptima or a Health Network for a Member who is eligible for services from a Local Education Agency (LEA).

II. POLICY

A. A Local Education Agency (LEA) provides certain Medically Necessary preventive, diagnostic, therapeutic, and rehabilitative services to eligible Members age three (3) years and older who are identified as Children with Special Health Care Needs (CSHCN) while school is in session.

B. A Member may receive LEA services from his or her LEA in accordance with the Member's Individualized Education Plan (IEP) or Individual Family Service Plan (IFSP).

C. A Member may receive an IEP or IFSP from his or her LEA in accordance with applicable state and federal regulations.

D. LEA educational support services may include, but are not limited to, the following, when identified on the Member's IEP or IFSP:

1. Health and mental health evaluation;

    a. Health and nutritional assessment and education;

    b. Developmental assessment;

    c. Vision assessment;

    d. Hearing assessment

    e. Education and psychosocial assessment;

    f. Psychological and counseling services;

    g. Nursing services;

    h. School aid health services;

    i. Specialized medical transportation services and the associated mileage; and

For 20201105 BOD Review Only

Back to Agenda Back to Item

j. Therapy services.

E. CalOptima, a Health Network, LEA practitioner (e.g., school nurse), or the Member's Primary Care Practitioner (PCP) shall identify a Member eligible for LEA services, as specified in Section III.B.1. of this Policy.

F. Upon appropriate identification of a Member eligible for LEA services, CalOptima, a Health Network, or the Member's PCP, shall refer the Member to his or her LEA.

G. A Member's PCP shall collaborate with CalOptima or a Health Network and the LEA to coordinate the provision of Medically Necessary services identified on the Member's IEP or IFSP.

H. The LEA must provide education to community providers and families on IEPs, as well as when LEA services, as opposed to health plan services, should be requested.

I. CalOptima and its Health Networks are not responsible for the provision, or payment, of LEA services, except as specified in Section III.A.1-2 of this Policy. CalOptima and its Health Networks shall provide Medically Necessary Covered Services that are not available under the LEA.

1. Services available through an LEA are not Covered Services under CalOptima's contract with the Department of Health Care Services. Therefore, if a Member's parents exercise their right to opt out of LEA services, such services will not be covered and paid for by CalOptima or its Health Networks in lieu of otherwise available LEA services, which are paid for by the State.

J. Whenever the LEA services overlap with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, CalOptima and its Health Networks shall:

1. Assess what level of EPSDT Medically Necessary services the Member requires.

2. Determine what level of service (if any) is being provided by the LEA.

3. Coordinate the provision of services with the other entities, such as CalOptima and its Health Networks, to ensure such entities are not providing duplicative services, and that the child is receiving all Medically Necessary EPSDT services in a timely manner.

K. CalOptima and its Health Networks have the primary responsibility to provide all Medically Necessary EPSDT services, including services which exceed the amount provided by the LEA.

1. An LEA will never be considered the primary provider of Medically Necessary EPSDT services, as this is the responsibility of CalOptima and its Health Networks.

III. PROCEDURE

A. CalOptima or a Health Network shall ensure coordination of care and provision of Medically Necessary Covered Services identified on a Member's IEP or IFSP.

1. In order to ensure timely provision of Medically Necessary Covered Services, for children without an IEP and who have not previously received LEA physical therapy (PT), occupational therapy (OT), or speech therapy (ST) services, will receive an initial, six (6)-month authorization for requested LEA services based on a Medical Necessity determination. After the initial six (6)-month authorization, a denial from the Member's LEA for LEA services is

For 20201105 BOD Review Only

Back to Agenda Back to Item

required prior to CalOptima's authorizing ongoing services beyond the initial six (6)-month authorization period.

2. CalOptima shall provide LEA services, PT/OT/ST for continuation while school is not in session during hiatus/vacation periods when services cannot be provided by the LEA.

3. CalOptima shall not furnish services during the operative period of the LEA (i.e., the school year) if the services can be provided by the LEA.

B. A Member's PCP shall:

1. Identify a Member eligible for LEA services through:

a. Pediatric prevention screening;

b. Developmental screening;

c. Case management referrals;

d. Utilization Management (UM) referrals;

e. Parental referrals; and

f. Community referrals, such as the Regional Center of Orange County (RCOC);

2. Refer the Member to his or her LEA, upon appropriate identification;

3. Transfer the Member's Medical Records to the LEA in a timely manner, when requested, in accordance with CalOptima Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities.

4. Collaborate with the LEA in the development of the IEP, or IFSP, for a Member;

5. Coordinate the provision of Medically Necessary Covered Services with CalOptima, or the Member's Health Network, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals; and

6. Coordinate LEA services for a Member.

C. Notwithstanding a Member's eligibility for or receipt of LEA services, a Member's PCP shall function as a Medical Home, providing all appropriate screening, preventive, assessment, treatment planning, and coordination of Medically Necessary services in accordance with CalOptima Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities

For 20201105 BOD Review Only

D. CalOptima Policy GG.1508: Authorization and Processing of Referrals
E. Department of Health Care Services Policy Letter (PL) 00-06: Managed Care Plan Relationships with Local Education Agency Providers
F. Department of Health Care Services All Plan Letter (APL) 19-010: Requirements for Coverage of EPSDT Services for Members Under Age 21
G. California Education Code, §§56032, 56340 et seq.
H. California Government Code, §95020
I. Welfare and Institutions Code §14132.06(h)
J. Title 22, California Code of Regulations, §§51096, 51309, 51323, 51360, 51190.1 through 51190.4, and 51535.5
K. Title 34, Code of Federal Regulations (CFR.) §300.323(c)
L. Title 35, Code of Federal Regulations (CFR.), §300.34
M. Title 42, Code of Federal Regulations (CFR.), §§431.53 and 440.130

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
10/31/17	Department of Health Care Services
01/13/16	Department of Health Care Services
09/23/20	Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2009	GG.1321	Coordination of Care for Local Education Agency Services	Medi-Cal
Revised	11/01/2015	GG.1321	Coordination of Care for Local Education Agency Services	Medi-Cal
Revised	01/01/2017	GG.1321	Coordination of Care for Local Education Agency Services	Medi-Cal
Revised	06/01/2017	GG.1321	Coordination of Care for Local Education Agency Services	Medi-Cal
Revised	07/01/2018	GG.1321	Coordination of Care for Local Education Agency Services	Medi-Cal
Revised		GG.1321	Coordination of Care for Local Education Agency Services	Medi-Cal

For 20201105 BOD Review Only

IX. GLOSSARY

Term	Definition
CalOptima	For purposes of this policy, CalOptima means CalOptima Direct and CalOptima Community Network (CCN).
Children with Special Health Care Needs (CSHCN)	Children who have or are at increased risk for chronic physical, behavioral, developmental, or emotional conditions, and who also require health care or related services of a type or amount beyond that required by children generally. The identification, assessment, treatment, and coordination of care for CSHCN shall comply with the requirements of Title 42, CFR, Sections 438.208(b)(3) and (b)(4), and 438.208(c)(2), (c)(3), and (c)(4).
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.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	A comprehensive and preventive child health program for individuals under the age of twenty-one (21) years. EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.
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.
Individual Family Service Plan (IFSP)	A written plan for providing early intervention services to a child eligible under the Individual with Disability Education Act (IDEA) and the child's family. The IFSP enables the family and service provider(s) to work together as equal partners in determining the early intervention services that are required for the child with disabilities and the family.
Individualized Education Plan (IEP)	A written document for an individual with exceptional needs that is developed, reviewed, and revised in a meeting in accordance with Sections 300.320 to 300.328, inclusive, of Title 34 of the Code of Federal Regulations and California Education Code, Title 2, Division 4, Part 30. It also means "individualized family service plan" as described in Section 1436 of Title 20 of the United States Code if the individualized education program pertains to an individual with exceptional needs younger than three (3) years of age.
Local Education Agency (LEA)	The governing body of any school district or community college district, county office of education, a charter school, a state special school, a California State University campus, or a University of California campus.

For 2020 IOS POD Review Only

Term	Definition
Medical Home	A place where a Member's medical information is maintained, and care is accessible, continuous, comprehensive and culturally competent. A Medical Home shall include, at a minimum: a Primary Care Physician (PCP) who provides continuous and comprehensive care; a physician-directed medical practice where the PCP leads a team of individuals who collectively take responsibility for the ongoing care of a Member; whole person orientation, where the PCP is responsible for providing all of the Member's health care needs or appropriately coordinating care; optimization and accountability for quality and safety by the use of evidence-based medicine, decision support tools, and continuous quality improvement; ready access to assure timely preventive, acute, and chronic illness treatment in the appropriate setting; and payment which is structured based on the value of the patient-centered Medical Home, and to support case management, coordination of care, enhanced communication, access and quality measurement services.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v). For EPSDT population, state and federal law define a service as "medically necessary" if the service is necessary to correct or ameliorate defects and physical and/or mental illnesses and conditions. A BHT service need not cure a condition in order to be covered. Services that maintain or improve the child's current health condition are considered a clinical benefit and must be covered.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the Medical Home for Members.

1

For 2020 IGS POD Preview Only

Policy:	MA.6044
Title:	**Coverage of Solid Organ and Stem Cell Transplants**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	
Effective Date:	12/05/2019
Revised Date:	01/01/2021
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

For 20201105 BOD Review Only

I. PURPOSE

This policy defines the coverage of Solid Organ and Stem Cell Transplants and related care and services for CalOptima Members in the OneCare and OneCare Connect Programs.

II. POLICY

A. A Solid Organ or Stem Cell Transplant shall be a Covered Service upon CalOptima's or a Health Network's determination that the Member is a candidate for a Transplant, is compliant with all requirements, and does not have significant contraindications for the Transplant.

B. CalOptima or a Health Network shall be responsible for the provision and payment of Covered Services related to a Transplant including the following:

1. Pre-transplant evaluation, including physician, psychological and social work consultations, necessary lab work and imaging;

2. Evaluation of potential Donors and organ/stem cell procurement fees, excluding procurement fees for kidney transplants which shall be the responsibility of Original Medicare Fee for Service program;

3. Transplant care, including inpatient facility and professional fees:

4. Post-transplant care, including Medically Necessary immunosuppressant drugs.

C. A Solid Organ or Stem Cell Transplant and related services shall be Covered Services if:

1. A Provider or Practitioner obtains prior authorization for these services from CalOptima or a Health Network in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals. The Transplant meets Medically Necessity and utilization review criteria and guidelines for coverage of the Solid Organ or Stem Cell Transplant and related services as described in CalOptima Policy GG.1535: Utilization Review Criteria and Guidelines.

2. The Transplant is performed at an approved facility, as set forth in Section III.A. of this Policy; and

Back to Agenda Back to Item

3. The Member is accepted at the approved facility for the following Transplants

    a. Heart;

    b. Lung;

    c. Heart/Lung;

    d. Kidney;

    e. Pancreas;

    f. Kidney/Pancreas;

    g. Liver;

    h. Intestine;

    i. Liver/Intestine; and

    j. Stem Cell.

D. CalOptima or a Health Network shall not approve the following Transplants:

1. Transplants that are experimental/investigational in nature, unless in a qualified Medicare-approved clinical trial;

2. Combined kidney and liver Transplant;

3. Pancreas Transplant for diabetic Members who have not experienced end stage renal failure secondary to diabetes;

4. Partial pancreatic tissue transplantation;

5. Adult liver transplantation for malignancies (excluding hepatocellular carcinoma); and

6. Nationally non-covered indications in the respective National Coverage Determinations.

E. Routine costs for Investigational Services associated with a Clinical Trial may be covered by CalOptima or a Health Network in accordance with CalOptima Policy GG.1102: Experimental and Investigational Service Coverage.

F. CalOptima or a Health Network shall provide notification on decisions for services requiring prior authorization in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

G. When CalOptima or a Health Network authorize a Member to receive a Transplant outside of CalOptima's Service Area, CalOptima or a Health Network shall cover reasonable expenses for transportation to and lodging at the distant location for the Member and a companion.

H. Transplants not covered under OneCare or OneCare Connect programs, may be covered under the CalOptima Medi-Cal program as set forth in CalOptima Policy GG.1105: Coverage of Organ and Tissue Transplants.

For 20201105 BOD Review Only

III. PROCEDURE

A. Centers for Medicare & Medicaid Services (CMS)-approved Transplant Centers

1. A Transplant must be performed in a CMS-approved Transplant Center for that specific Transplant type; as required by CMS and the decision based on Medicare coverage criteria, including national and local coverage determinations (NCDs and LCDs)

2. CalOptima or a Health Network shall identify a CMS-approved Transplant Center, based upon information, documentation, and representation received from CMS.

3. CalOptima or a Health Networks' Chief Medical Officer (CMO) or Designee shall have the authority to determine coverage of a Transplant performed at a CMS-approved Transplant Center, whose certification by CMS is probationary.

4. If a CMS-approved Transplant Center loses its certification by CMS, CalOptima shall have the right to transfer any Members who are awaiting Transplants at such facility.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee for Service, and Medicaid Managed Care Programs for Years 2021 and 2022 (Final Rule CMS-4190-F1)
~~C.~~D. CalOptima Policy GG.1102: Experimental and Investigational Service Coverage
~~D.~~E. CalOptima Policy GG.1105: Coverage of Organ and Tissue Transplants
~~E.A. CalOptima Policy GG.1508: Authorization and Processing of Referrals~~
F. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
G. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~G.~~H. CalOptima Policy GG.1535: Utilization Review Criteria and Guidelines
~~H.~~I. CalOptima Utilization Management Program

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

For 2020105 POD Review Only

Action	Date	Policy	Policy Title	Program(s)
Effective	12/05/2019	MA.6044	Coverage of Solid Organ and Stem Cell Transplants	OneCare OneCare Connect
Revised	01/01/2021	MA.6044	Coverage of Solid Organ and Stem Cell Transplants	OneCare OneCare Connect

1
2
3

For 20201105 BOD Review Only

IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the t~~T~~hree-w~~W~~ay A~~a~~greement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Donor	For the purposes of this policy, refers to an individual who undergoes a surgical operation for the purpose of donating a solid organ or stem cells for Transplant.

For 2020 10-5 BOD Review Only

Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).~~Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.~~
Member	~~An enrollee~~ A beneficiary ~~of~~enrolled in a CalOptima program.
Practitioner	OneCare: A licensed independent practitioner including but not limited to a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist furnishing Covered Services as described in OneCare Policies. OneCare Connect: A licensed independent practitioner including but not limited to a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist furnishing Covered Services as described in OneCare Connect Policies.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, ~~Physician Medical Group~~physician group, or other person or institution who furnishes Covered Services.
Service Area	The ~~geographical area that DHCS and/authorizes CalOptima to operate in. A Service Area may include designated ZIP Codes within a~~ county or counties that CalOptima is approved to operate in under the terms of CalOptima's contracts with DHCS and CMS.
Stem Cell Transplant	A process which includes mobilization, harvesting, and transplant of peripheral blood stem cells and the administration of high dose chemotherapy or radiotherapy prior to the actual transplant.

For 2020 10/5 BOD Review Only

Term	Definition
Transplant	A non-experimental procedure for Solid Organ or Stem Cell Transplant.
Transplant Center	For the purposes of this policy, refers to facilities that are approved by the Centers for Medicare & Medicaid (CMS) to provide specific transplant services.

1

For 20201105 BOD Review Only

Policy:	MA.6044
Title:	**Coverage of Solid Organ and Stem Cell Transplants**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	
Effective Date:	12/05/2019
Revised Date:	01/01/2021
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

For 20201105 BOD Review Only

I. PURPOSE

This policy defines the coverage of Solid Organ and Stem Cell Transplants and related care and services for CalOptima Members in the OneCare and OneCare Connect Programs.

II. POLICY

A. A Solid Organ or Stem Cell Transplant shall be a Covered Service upon CalOptima's or a Health Network's determination that the Member is a candidate for a Transplant, is compliant with all requirements, and does not have significant contraindications for the Transplant.

B. CalOptima or a Health Network shall be responsible for the provision and payment of Covered Services related to a Transplant including the following:

1. Pre-transplant evaluation, including physician, psychological and social work consultations, necessary lab work and imaging;

2. Evaluation of potential Donors and organ/stem cell procurement fees, excluding procurement fees for kidney transplants which shall be the responsibility of Original Medicare Fee for Service program;

3. Transplant care, including inpatient facility and professional fees:

4. Post-transplant care, including Medically Necessary immunosuppressant drugs.

C. A Solid Organ or Stem Cell Transplant and related services shall be Covered Services if:

1. A Provider or Practitioner obtains prior authorization for these services from CalOptima or a Health Network in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals. The Transplant meets Medically Necessity and utilization review criteria and guidelines for coverage of the Solid Organ or Stem Cell Transplant and related services as described in CalOptima Policy GG.1535: Utilization Review Criteria and Guidelines.

2. The Transplant is performed at an approved facility, as set forth in Section III.A. of this Policy; and

Back to Agenda Back to Item

3. The Member is accepted at the approved facility for the following Transplants

    a. Heart;

    b. Lung;

    c. Heart/Lung;

    d. Kidney;

    e. Pancreas;

    f. Kidney/Pancreas;

    g. Liver;

    h. Intestine;

    i. Liver/Intestine; and

    j. Stem Cell.

D. CalOptima or a Health Network shall not approve the following Transplants:

1. Transplants that are experimental/investigational in nature, unless in a qualified Medicare-approved clinical trial;

2. Combined kidney and liver Transplant;

3. Pancreas Transplant for diabetic Members who have not experienced end stage renal failure secondary to diabetes;

4. Partial pancreatic tissue transplantation;

5. Adult liver transplantation for malignancies (excluding hepatocellular carcinoma); and

6. Nationally non-covered indications in the respective National Coverage Determinations.

E. Routine costs for Investigational Services associated with a Clinical Trial may be covered by CalOptima or a Health Network in accordance with CalOptima Policy GG.1102: Experimental and Investigational Service Coverage.

F. CalOptima or a Health Network shall provide notification on decisions for services requiring prior authorization in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

G. When CalOptima or a Health Network authorize a Member to receive a Transplant outside of CalOptima's Service Area, CalOptima or a Health Network shall cover reasonable expenses for transportation to and lodging at the distant location for the Member and a companion.

H. Transplants not covered under OneCare or OneCare Connect programs, may be covered under the CalOptima Medi-Cal program as set forth in CalOptima Policy GG.1105: Coverage of Organ and Tissue Transplants.

For 20201105 BOD Review Only

III. PROCEDURE

A. Centers for Medicare & Medicaid Services (CMS)-approved Transplant Centers

1. A Transplant must be performed in a CMS-approved Transplant Center for that specific Transplant type; as required by CMS and the decision based on Medicare coverage criteria, including national and local coverage determinations (NCDs and LCDs)

2. CalOptima or a Health Network shall identify a CMS-approved Transplant Center, based upon information, documentation, and representation received from CMS.

3. CalOptima or a Health Networks' Chief Medical Officer (CMO) or Designee shall have the authority to determine coverage of a Transplant performed at a CMS-approved Transplant Center, whose certification by CMS is probationary.

4. If a CMS-approved Transplant Center loses its certification by CMS, CalOptima shall have the right to transfer any Members who are awaiting Transplants at such facility.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee for Service, and Medicaid Managed Care Programs for Years 2021 and 2022 (Final Rule CMS-4190-F1)
D. CalOptima Policy GG.1102: Experimental and Investigational Service Coverage
E. CalOptima Policy GG.1105: Coverage of Organ and Tissue Transplants
F. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
G. CalOptima Policy GG.1508: Authorization and Processing of Referrals
H. CalOptima Policy GG.1535: Utilization Review Criteria and Guidelines
I. CalOptima Utilization Management Program

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

For 20201105 POD Review Only

Action	Date	Policy	Policy Title	Program(s)
Effective	12/05/2019	MA.6044	Coverage of Solid Organ and Stem Cell Transplants	OneCare OneCare Connect
Revised	01/01/2021	MA.6044	Coverage of Solid Organ and Stem Cell Transplants	OneCare OneCare Connect

1
2
3

For 20201105 BOD Review Only

IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the three-way agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Donor	For the purposes of this policy, refers to an individual who undergoes a surgical operation for the purpose of donating a solid organ or stem cells for Transplant.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
Member	A beneficiary enrolled in a CalOptima program.

For 2020 10-5 BOD Review Only

Term	Definition
Practitioner	OneCare: A licensed independent practitioner including but not limited to a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist furnishing Covered Services as described in OneCare Policies. OneCare Connect: A licensed independent practitioner including but not limited to a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist furnishing Covered Services as described in OneCare Connect Policies.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.
Service Area	The county or counties that CalOptima is approved to operate in under the terms of CalOptima's contracts with DHCS and CMS.
Stem Cell Transplant	A process which includes mobilization, harvesting, and transplant of peripheral blood stem cells and the administration of high dose chemotherapy or radiotherapy prior to the actual transplant.
Transplant	A non-experimental procedure for Solid Organ or Stem Cell Transplant.
Transplant Center	For the purposes of this policy, refers to facilities that are approved by the Centers for Medicare & Medicaid (CMS) to provide specific transplant services.

1

For 20201105 BOD Review Only

Policy:	MA.6101
Title:	**Medicare Part D Coverage Determination**
Department:	Medical Management
Section:	Pharmacy Management
CEO Approval:	
Effective Date:	01/01/2006
Revised Date:	
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

For 20201001 BOD Review Only

I. PURPOSE

This policy describes CalOptima's process for determination of drug benefit coverage and/or payment of drug benefits for Medicare Part D.

II. POLICY

A. A Coverage Determination (CD) is any determination (i.e., an approval or denial) made by CalOptima with respect to the following:

1. A decision about whether to provide or pay for a drug that the Member believes may be covered by CalOptima, including a decision not to pay because:

   a. The drug is not on the plan's Formulary,

   b. The drug is determined not to be Medically Necessary,

   c. The drug is furnished by an out-of-network pharmacy, or

   d. The drug is otherwise excluded under Medicare Part D, Medicare Part B, and/or Medi-Cal.

2. Failure to provide a CD in a timely manner, when a delay would adversely affect the health of the Member;

3. A decision concerning a Tiering Exceptions request under Title 42 of the Code of Federal Regulations, Section 423.578(a);

4. A decision concerning a Formulary Exceptions request under Title 42 of the Code of Federal Regulations, Section 423.578(b);

5. A decision on the amount of cost-sharing for a drug; or

6. A decision whether a Member has, or has not, satisfied a Prior Authorization or other Utilization Management requirement.

B. Who May Request a Coverage Determination (CD)

Back to Agenda Back to Item

1. Medicare Part D requests for coverage may be made by a Member, a Member's Prescriber or staff of Prescriber's office acting on the Prescriber's behalf, or a Member's Authorized Representative.

C. With respect to CDs, a Member shall have the following rights:

1. The right to a timely decision;

2. The right to an expedited decision, subject to the provisions of this policy;

3. The right to receive written notice of Tolling;

4. The right to receive detailed written notice of CalOptima's decision;

5. The right to request and receive Appeal data from CalOptima;

6. The right to receive notice when a request is forwarded to the Independent Review Entity (IRE); and

7. The right to a reconsideration by the IRE.

D. Subject to the provisions of this policy, a Member, a Member's Authorized Representative, or a Member's Prescriber may request a Medicare Part D Exception under the following circumstances:

1. To obtain a non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier;

2. The requested drug regimen exceeds CalOptima limitations for quantity, refill frequency, duration of therapy, or does not meet Step Therapy restrictions;

3. The requested drug is not on the Formulary; or

4. To waive a Prior Authorization (PA) or other Utilization Management (UM) requirement.

E. A request for a Medicare Part D Formulary Exception will require the Member's Prescriber to provide medical justification or a supporting statement consistent with the requirements set forth in Title 42 of the Code of Federal Regulations, Section 423.578(b)(5).

F. CalOptima shall make a CD within the time frames defined within this Policy.

1. If additional information is required, CalOptima shall make reasonable and diligent efforts to obtain the necessary information within the defined time frames from sources which may include, but are not limited to, the Prescriber, the Member, and other healthcare Providers.

2. If the necessary information is not available within the defined time frames, CalOptima shall make its determination based upon the evidence that exists, if any.

3. If a Medicare Part D CD is not made within the defined time frames, CalOptima shall auto-forward the request to the IRE.

G. CalOptima shall accept CD requests, Exception requests, and Prescriber Supporting Statements in the following formats:

For 20201001 BOD Review Only

Back to Agenda Back to Item

1. Telephone;

2. Mail;

3. Facsimile; and

4. CalOptima website.

5. A CD request which involves direct payment or reimbursement to the Member shall only be accepted in writing.

6. CalOptima shall not require a written request or a supporting statement to be provided on a specific form.

H. Subject to the provisions of this Policy, CalOptima shall notify a Member, a Member's Authorized Representative, a Member's Prescriber, and a Member's Provider of services of the CD outcome in writing and, in some cases, orally.

I. CalOptima's Medical Director shall be responsible for ensuring the clinical accuracy of all Coverage Determinations involving Medical Necessity. The Medical Director shall be a physician with a current license to practice medicine in the state of California.

1. A physician or other appropriate health care professional with sufficient medical expertise and knowledge of coverage criteria shall review partially or fully adverse Medical Necessity CD decisions. The physician or other health care professional must have a current and unrestricted license to practice within the scope of his or her profession in the state of California.

2. A pharmacist is considered an appropriate health care professional for purposes of meeting this requirement.

J. Member Notification

1. CalOptima shall maintain a List of Covered Drugs (Formulary), including restrictions such as Quantity Limit (QL), Prior Authorization (PA), and Step Therapy (ST) requirements, and shall make the Formulary available to Members on its Website. Members may also request a mailed copy of the Formulary.

2. CalOptima shall provide Members with information about the CD process, including how to contact CalOptima, in the Evidence of Coverage and Member Handbook.

3. All Member-facing materials shall be reviewed and approved by CMS, consistent with CalOptima Policy MA.2001: Marketing Material Standards.

III. PROCEDURE

A. When a claim for a potentially Part D drug rejects at the pharmacy point of service (POS) with an electronic notice indicating that the drug is subject to a PA or other UM requirement, the POS pharmacist or other pharmacy personnel shall provide the Member with the standardized Form CMS-10147, Medicare Prescription Drug Coverage and Your Rights.

B. Requesting a Coverage Determination (CD)

For 2020.001 BOD Review Only

1. A Member, a Member's Authorized Representative, a Member's Prescriber, ~~a Provider that furnishes or intends to furnish services to a Member~~, or a Provider of health care services for the Member, as described in Section II.B of this Policy, may submit a CD request orally, or in writing, indicating the request to be either "standard" or "expedited."

    a. A Member's Authorized Representative shall submit a valid signed Form CMS-1696 or other equivalent notice to CalOptima.

    b. CalOptima shall include a copy of the original signed Form CMS-1696 or other equivalent notice or conforming written instrument with each new request for a Coverage Determination.

    c. CalOptima shall not require the Member to sign a new form for the life of the Coverage Determination, or for any new Coverage Determination filed by the Authorized Representative within one (1) calendar year from the date that a valid form was executed.

2. A CD request for services that have already been furnished:

    a. Shall not be expedited.

    b. Shall be accepted only in written formats when direct payment to the Member is also requested.

C. Requesting an Expedited CD

1. A Member, a Member's Authorized Representative, a Member's Prescriber~~, a Provider that furnishes or intends to furnish services to a Member~~, or a Provider of health care services for the Member, as described in Section II.B of this policy, may request CalOptima to expedite a CD if waiting for a standard CD may seriously jeopardize the Member's life, health, or ability to regain maximum function.

2. CalOptima shall not accept any request to expedite a CD for drugs already furnished to the Member.

3. CalOptima shall provide an expedited CD if:

    a. A request to expedite is made or supported by a Prescriber and the Prescriber indicates, either orally or in writing, that applying the standard time for making a determination may seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function; or

    b. A request to expedite is made by a Member or Member's Authorized Representative and CalOptima finds that the Member's health, life, or ability to regain maximum function may be seriously jeopardized by waiting for a standard CD.

4. If CalOptima denies a request to expedite a CD, CalOptima shall proceed as follows:

    a. Transfer and process the request under the standard CD procedures as set forth in this policy.

    b. Provide the Member or Member's Authorized Representative and the Prescriber with prompt verbal notice of the denial that:

For 20201001 BOD Review Only

i. Explains that CalOptima shall process the request within the standard CD timeframe;

ii. Informs the Member of the right to file an expedited grievance if he or she disagrees with CalOptima's decision not to expedite the CD;

iii. Informs the Member of the right to resubmit a request for an expedited CD with the Prescriber's support; and

iv. Provides instructions about CalOptima's expedited grievance process and time frames.

c. Deliver a written notice, equivalent to the oral notice described in Section III.C.4.b of this Policy, to the Member or Member's Authorized Representative and the Prescriber within three (3) calendar days after providing verbal notice.

D. If CalOptima makes a fully or partially favorable decision:

1. CalOptima shall effectuate the authorization retroactive to the date of the first request made during the contract year, or retroactive to the date of service indicated in the request, whichever comes earlier.

2. For an Exception request, the coverage duration of the approval shall be for the remainder of the contract year.

3. For a Non-Exception request, the coverage duration of the approval shall be consistent with the duration specified in the Formulary Prior Authorization criteria as calculated based on the date the decision is made. If the criteria does not specify the coverage duration, then the coverage duration shall be for the remainder of the plan year.

4. The coverage duration applies so long as:

a. The Prescriber continues to prescribe the drug; and

b. The drug continues to be considered safe for treating the Member's disease or medical conditions; and

c. The Member's enrollment period has not expired.

5. CalOptima shall not require the Member to request approval for a refill or a new prescription to continue using the approved drug after the refills for the initial prescription are exhausted, subject to the provisions of this policy.

6. CalOptima shall provide notification to the Member or the Member's Authorized Representative and the Prescriber (as applicable), as described in Section III.M. of this Policy.

E. If CalOptima makes a fully or partially unfavorable decision, CalOptima shall provide notification to the Member or the Member's Authorized Representative and the Prescriber (as applicable), as described in Section III.M. of this Policy.

F. Requesting a Tiering Exception

1. A request for an Exception to CalOptima's tiered cost-sharing structure (Tiering Exception) shall include an oral or written supporting statement from the Prescriber that the drug in the lower cost-sharing tier for treatment of the Member's condition:

For 20201001 BOD Review Only

a. Would not be as effective as the requested drug in the higher cost-sharing tier;

b. Would have adverse effects; or

c. Both of the above.

2. CalOptima is not required to approve a Tiering Exception for a drug in a higher cost-sharing tier at the generic tier cost-sharing level as long as CalOptima maintains a separate tier that only includes generic drugs as defined in Title 42 of the Code of Federal Regulations.

3. Under Title 42 of the Code of Federal Regulations, Section 423.578(c)(4)(iii), a Tiering Exception may not be requested for a Non-Formulary drug approved under the Formulary Exception process.

4. CalOptima shall grant a Tiering Exception if it determines that the drug in the lower cost-sharing tier for treatment of the Member's condition would not be as effective for the Member as the requested drug and/or would have adverse effects.

G. Requesting a Formulary Exception

1. A request for a Formulary Exception to obtain a Covered Part D Drug that is not included on CalOptima's Formulary shall include an oral or written supporting statement from the Prescriber documenting that the requested drug is Medically Necessary to treat the Member's disease or medical condition because all Covered Part D Drugs on any tier of the CalOptima Formulary for treatment of the same condition:

a. Would not be as effective for the Member as the requested drug;

b. Would have adverse effects for the Member; or

c. Both of the above.

2. A request for a Formulary Exception to obtain a Covered Part D Drug that is included on CalOptima's Formulary and subject to a Step Therapy restriction which the requestor believes should not apply shall include an oral or written supporting statement from the Prescriber documenting that the requested drug is Medically Necessary to treat the Member's disease or medical condition because the prescription drug alternative(s) listed on the Formulary:

a. Has been ineffective in the treatment of the Member's disease or medical condition; or

b. Based on sound clinical and medical and scientific evidence, and the known relevant physical or mental characteristics of the Member, and the known characteristics of the drug regimen, it is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

3. A request for a Formulary Exception to obtain a Covered Part D Drug that is included on CalOptima's Formulary and subject to a Quantity Limit restriction which the requestor believes should not apply shall include an oral or written supporting statement from the Prescriber documenting that the requested drug is Medically Necessary to treat the Member's disease or medical condition because the number of doses available under a dose restriction (Quantity Limit) for the prescription drug:

a. Has been ineffective in the treatment of the Member's disease or medical condition; or

For 20201001 BOD Preview Only

b. Based on sound clinical, medical, and scientific evidence, and the known relevant physical or mental characteristics of the Member, and the known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

4. A request for a Formulary Exception to obtain a Covered Part D Drug that is included on CalOptima's Formulary and subject to a Prior Authorization restriction, which the requestor believes should not apply, shall include an oral or written supporting statement from the Prescriber documenting that:

   a. The requested drug is Medically Necessary to treat the Member's disease or medical condition; and

   b. The Member would suffer adverse effects if he or she were required to satisfy the PA requirement.

5. Under Title 42 of the Code of Federal Regulations, Section 423.578(f), nothing in the regulations or in this Policy should be construed to mean that the Prescriber's Supporting Statement will result in an automatic favorable determination.

6. CalOptima may grant a Formulary Exception request if it determines that:

   a. The requested drug is Medically Necessary, based on the physician's or other Prescriber's supporting statement; and

   b. CalOptima determines that all Covered Part D Drugs on any tier of the Formulary for treatment of the same condition:

      i. May not be as effective for the Member as the requested drug;

      ii. May have adverse effects for the Member; or

      iii. Both of the above.

7. If CalOptima approves a Formulary Exception request to obtain a Covered Part D Drug:

   a. The cost-sharing tier for the approved drug under the Formulary Exceptions process shall be:

      i. Equivalent to the higher cost-sharing tier for all brand name drugs; or

      ii. Equivalent to the lower cost-sharing tier for all generic drugs.

   b. CalOptima may choose not to require the Member to resubmit a Formulary Exception request at the beginning of a new plan year. CalOptima may auto-extend Formulary Exception approvals for the following year on a case-by-case basis. If applicable, Members will be notified with an approval letter indicating the new expiration date.

H. Requesting Retrospective Coverage and Payment Reimbursement for a Cash Purchase

1. Any decision made by CalOptima about reimbursing a Member for a drug and any decision to reimburse the Member for all or part of a cost-sharing amount is a CD.

For 20201001 BOD Review Only

Back to Agenda Back to Item

2. A request for reimbursement shall be made in writing by one (1) of the individuals described in Section II.B of this Policy.

3. CalOptima shall accept a CD for payment reimbursement for a drug.

   a. CalOptima's Prescription Drugs Payment Request Form may be used to request reimbursement, but shall not be required.

   b. Copies of prescriptions and receipts may be included with a reimbursement request, but shall not be required.

4. When a reimbursement request must be resolved under the Formulary or Tiering Exceptions process, CalOptima shall not toll the timeframe.

5. If CalOptima does not have all the information needed to make a decision, reasonable and diligent efforts shall be made to obtain the missing information within the time frames described in Section III.K. of this Policy.

6. CalOptima shall make a CD for a drug dispensed as a Cash Purchase at a Non-Participating Pharmacy if:

   a. CalOptima cannot reasonably expect the Member to obtain such drugs at a Participating Pharmacy in a timely manner; and

   b. The Member does not access covered drugs at non-Participating Pharmacies on a routine basis.

   c. For purposes of this policy, accessing covered drugs at a Non-Participating Pharmacy on a routine basis shall be construed to mean more than one occurrence per drug per twelve (12)-month period.

7. CalOptima shall make a CD for a drug dispensed as a Cash Purchase at a Participating Pharmacy if the circumstances for the Cash Purchase are reasonable, such as:

   a. When the Pharmacy's or CalOptima's PBM's system is down;

   b. When a family Member or other person who is filling a prescription on the Member's behalf does not have the Member's benefit card and the Member is not in the Pharmacy's system;

   c. When the Pharmacy or CalOptima's PBM mistakenly charge the Member for the drug; or

   d. The prescription was written in connection with a medical emergency or urgent care.

8. If a Member accesses a Covered Part D Drug as a Cash Purchase, the Member may be required to pay the out-of-network differential (that is, the difference between the Non-Participating Pharmacy's usual and customaryer (U&C) price and CalOptima's negotiated rate for such Covered Part D Drug) if the conditions in Section III.H.6 and III.H.7 are not met.

9. The Member shall be required to pay their applicable cost-sharing.

I. Request for CD for Medicare Part B versus Medicare Part D Drugs

For 20201001 BOD Review Only

1. CalOptima shall not consider a drug prescribed to a Member a Covered Part D Drug if payment for such drug is available (or would be available but for the application of a deductible) under Medicare Part A or Medicare Part B for that Member.

2. CalOptima relies on the point of service pharmacy to communicate to CalOptima the diagnosis provided by the Prescriber to determine whether benefit coverage is required for select covered drugs.

    a. In determining drug coverage under Medicare Part D versus Medicare Part B, CalOptima accepts diagnoses documented on the face of the prescription.

    b. Nebulized Inhalation Drugs: If the patient residence code is "3", or "9" indicating the Member is in a Nursing Facility or Intermediate Care Facility, then inhalation drugs used with a nebulizer are Medicare Part D benefits. Inhalation drugs are covered under Medicare Part B when used with a nebulizer in the home.

    c. Oral Anti-Cancer Drugs: Certain oral chemotherapy agents used in cancer treatment are covered by Medicare Part B, as determined by CMS.

    d. Immunosuppressive Drugs: Drugs used in immunosuppressive therapy for a Member who has received a Medicare covered organ transplant are covered under Medicare Part B; else these drugs are likely used for auto-immune conditions and are covered by Medicare Part D benefits.

    e. Drugs for Dialysis-Related Conditions: Drugs used for renal dialysis-related conditions for Member receiving renal dialysis services may have a point of service PA requirement to determine if payment is included in the Medicare Part B bundled payment to a dialysis facility.

    f. In institutional settings, CalOptima will also accept diagnoses documented in the medical record by the Prescriber.

    g. The point of service Pharmacy's communication of the diagnosis to CalOptima or CalOptima's PBM Help Desk may enable the Pharmacy to receive an immediate override for the applicable benefit when the diagnosis supports coverage under Medicare Part B or Medicare Part D.

3. Daily on business days, CalOptima shall identify all new pharmacy claim rejections for immunosuppressive drugs for the purpose of making an administrative prospective payment determination.

    a. CalOptima shall contact the Member's Pharmacy, the Member's Prescriber, and/or the Member to collect pertinent medical history and diagnosis.

    b. Administrative prospective payment determinations shall be made within one (1) business day of identification of the rejected claim.

    c. An administrative prospective payment determination shall not be treated as a request for CD.

4. If CalOptima determines that the diagnosis is not consistent with Medicare Part D coverage, the request shall be denied as ~~a Covered Part D Drug.~~not meeting the definition of a Covered Part D Drug.

For 2020 1001 BOD Review Only

a. The Member or the Member's Authorized Representative and the Prescriber shall receive a Notice of Denial of Medicare Prescription Drug Coverage.

b. The Notice of Denial of Medicare Prescription Drug Coverage shall provide an explanation of the conditions of approval as a Medicare Part B Drug.

c. An administrative prospective payment determination of Medicare Part B versus Medicare Part D shall not be subject to CD requirements.

J. Time Frames for Completing Coverage Determinations

1. Standard Prospective Request

a. CalOptima shall complete the CD, notify the Member or Member's Authorized Representative and the Prescriber, and effectuate the decision, if applicable, as expeditiously as the Member's health condition requires, but no later than seventy-two (72) ~~calendar~~ hours after the date and time CalOptima received the request or, if the request involves a Formulary or Tiering Exception, the date and time CalOptima received the Prescriber's Supporting Statement.

2. Expedited Prospective Request

a. CalOptima shall complete the CD, notify the Member or Member's Authorized Representative and the Prescriber, and effectuate the decision, if applicable, as expeditiously as the Member's health condition requires, but no later than twenty-four (24) ~~calendar~~ hours after the date and time CalOptima received the request or, if the request involves a Formulary or Tiering Exception, the date and time CalOptima received the Prescriber's Supporting Statement.

3. Retrospective Request

~~a. Medicare Part D:~~

a. A retrospective request that does not involve direct payment to the Member shall be resolved under the procedures for standard prospective requests as described in this policy.

b. For a retrospective request involving direct payment to the Member, CalOptima shall complete the CD, notify the Member or Member's Authorized Representative and the Prescriber, and effectuate the decision, if applicable, no later than fourteen (14) calendar days after the date and time CalOptima received the request.

4. Time Frame Extension

a. Tolling a Medicare Part D Request for a Formulary or Tiering Exception

i. CalOptima shall not keep an Exception request open indefinitely if the Prescriber does not submit a supporting statement for the Medical Necessity of the requested drug.

ii. For standard and expedited prospective Exception requests, CalOptima shall toll the Exception request for up to seven (7)~~ten (10)~~ calendar days and make a CD at the end of the Tolling period with the best available information.

For 20201001 BOD Review Only

Back to Agenda Back to Item

iii. CalOptima shall provide written notification to the Member when a Part D Exception request is tolled to obtain a Prescriber Supporting Statement.

iv. Tolling shall not apply for Non-Exception requests.

v. Tolling shall not apply for retrospective payment requests.

5. Auto-forward

a. If CalOptima does not make a decision, or fails to provide notice of the decision, in the applicable timeframe, then within twenty-four (24) ~~calendar~~ hours of the expiration of the adjudication time frame CalOptima shall:

i. Forward the request and case file to the Independent Review Entity (IRE) for review; and

ii. Notify the Member that the decision was not made timely and that their request is being forwarded to the IRE, utilizing the "Notice of Case Status" instead of Form CMS-10146: Notice of Denial of Medicare Prescription Drug Coverage.

iii. If CalOptima discovers the untimely decision or notification more than twenty-four (24) ~~calendar~~ hours after the expiration of the adjudication time frame, then CalOptima shall forward the request to the IRE and provide the Member with the "Notice of Case Status" as quickly as possible, not to exceed one (1) business day after discovery.

iv. If CalOptima's decision was fully favorable and was made soon after the expiration of the adjudication time frame (within one (1) business day), then CalOptima shall not forward the request to the IRE nor provide the Member with the "Notice of Case Status."

K. Request for Additional Information

1. When CalOptima does not have all the information needed to make a coverage decision, CalOptima shall make reasonable and diligent efforts to obtain all necessary information, including medical records and other pertinent documentation, from the Member's Prescriber.

2. CalOptima shall make a minimum of one (1) attempt to obtain additional information within the applicable adjudication time frame. However, when possible, CalOptima shall use multiple means of communication, including:

a. Telephone;

b. Fax;

c. E-mail; and/or

d. Standard or overnight mail with certified return receipt.

3. The sufficiency of CalOptima's outreach efforts are determined on a case-by-case basis and are contingent upon the facts and circumstances of each case.

For 2020 1001 BOD Review Only

4. CalOptima shall document all requests for information and maintain that information with the case file. The documentation must include:

    a. A specific description of the required information;

    b. The name, phone number, fax number, e-mail and/or mailing address, as applicable, for the point of contact at CalOptima; and

    c. The date and time of each request, documented by date and time stamps on copies of a written request, call record, facsimile transmission, or e-mail. Call records should include specific information about who was contacted, what was discussed/requested, and what information was obtained by CalOptima.

5. Requests for information shall be made in a manner that increases the likelihood of making contact with the Prescriber and receiving the information.

    a. When possible, requests for additional information shall be made during normal business hours in the Prescriber's time zone. However, outreach must not be limited to business hours when the time frame is limited.

    b. CalOptima shall leverage its contractual relationship when the request involves the need for information from a contracted Provider.

6. The first request for information shall be made within the time frames indicated in the table below.

➔ **Priority**	**Standard Request**	**Expedited Request**
Medicare Part D	Twenty-Four (24) ~~Calendar~~ Hours	Upon Receipt

7. When deemed necessary on a case-by-case basis, network Prescribers who do not respond to requests for required additional information may be referred to CalOptima's Medical Director for review.

L. Refill Too Soon

1. CalOptima may grant an override for an early refill as an administrative override and will not require a CD.

    a. A vacation supply of up to ninety (90) calendar days may be granted at a frequency of one (1) override per calendar year per medication.

    b. A replacement supply of lost, stolen, or damaged medication may be granted at a frequency of one (1) override per calendar year per medication for a quantity up to the amount dispensed for the lost, stolen, or damaged medication prescription.

2. On a case-by-case basis, CalOptima may initiate a CD for an early refill request which exceeds one (1) request per medication per calendar year.

3. When the early refill request is for a Controlled Medication, CalOptima may require a CD and may require additional information on a case-by-case basis, as indicated by the facts and circumstances of each case, such as:

    a. Prescriber approval;

For 20201001 BOD Review Only

b. Documentation to support the Member's reason for the request; and/or

c. A police report.

M. Notification Standards

1. Written notification of a fully favorable decision must be written in a manner that is understandable to the Member and explain the conditions of the approval, including (but ~~are~~ not limited to):

   a. The duration of an approval;

   b. Limitations associated with an approval; and/or

   c. Any coverage rules applicable to subsequent refills.

2. Written notification of a fully or partially unfavorable decision must be specific to each individual case, written in a manner that is understandable to the Member, and provide:

   a. The specific reason for the denial that takes into account the Member's presenting medical condition, disabilities, and special language requirements, if any;

   b. A description of any applicable Medicare coverage rule or any other applicable Part D plan policy upon which the denial decision was based, including the type of information that should be submitted when seeking a Formulary or Tiering Exception, if applicable;

   c. Information regarding the right to appoint a representative to file an Appeal on the Member's behalf; and

   d. A description of the standard and expedited Redetermination processes and time frames.

3. Written notification is required for all unfavorable decisions (fully or partially unfavorable) pertaining to Medicare Part D.

4. Written notification is required for fully favorable decisions pertaining to Medicare Part D benefits.

5. CalOptima may make its initial notification orally so long as it also mails a written follow-up decision within three (3) calendar days of the oral notification. However, if a good faith effort was made but CalOptima is not able to provide verbal notice, written follow-up decision will be sent within the applicable adjudication timeframe. Oral notifications must satisfy the same requirements as written notifications, as described in Sections III.M.1 and III.M.2. of this Policy.

6. When CalOptima has the Member's telephone number on file and relies on it to provide oral notice, but is unable to reach the Member because it is either incorrect, out-of-service, or no person (or no voicemail system) answers, its good-faith effort to provide oral notice satisfies the notification requirement if:

   a. The good-faith effort is documented in writing and included in the case file,

   b. Written notice of the decision is sent to the Member within the adjudication timeframe~~, and~~.

For 20201001 BOD Preview Only

~~c. CalOptima is not at fault for its inability to reach the Member by phone.~~

7. When the Member's telephone number and/or mailing address is invalid or missing, CalOptima, or its downstream delegated entities, shall make a reasonable and diligent effort to obtain it, such as outreach to the Prescriber and/or dispensing pharmacy, if known, to request it. The outreach efforts shall be documented in writing and included in the case file.

8. Written notification to the Prescriber, as applicable, shall be communicated via facsimile.

   a. CalOptima or its delegated downstream entities shall document a copy of the notice, the date and time of facsimile transmission, and the final processing status of the transmission (successful or failed) in the case file.

   b. If the facsimile transmission is not successful, CalOptima or its delegated downstream entity shall attempt to re-send the facsimile and/or outreach to the Prescriber to obtain a working fax number and provide verbal notification of the decision.

9. Written notification to the Member or Member's Authorized Representative, as applicable, shall be communicated via postal mail. Letters shall be mailed in accordance with the delegated downstream entity and/or CalOptima facility mailing procedures.

10. Notification of the results of the Medicare Part D CD shall be provided to the Member, the Member's Authorized Representative, and/or the Member's Prescriber as indicated in the table below.

➔ **Requestor** 🡻 **Notification to…**	**Member**	**Member's Representative**	**Member's Prescriber**
Member	Required	Optional	Required
Member's Representative	Optional	Required	Optional
Member's Prescriber	Optional	Optional	Required (written notice is not required if oral notice is provided)

N. Documentation and Reporting

1. CalOptima's Customer Service Department shall track oral CD requests made by a Member or the Member's Authorized Representative in CalOptima's core system. CalOptima's Customer Service Department shall document in the core system, at a minimum, the date of receipt of a request for a CD.

2. CalOptima's Pharmacy Management Department shall track written CD requests made by a Member or Member's Authorized Representative in the PBM's Prior Authorization Database.

3. CalOptima's Pharmacy Management Department and delegated downstream entities shall track oral and written CD requests made by Prescribers and other Providers in the PBM's Prior Authorization Database.

4. CalOptima is responsible for reporting certain data related to CD requests, as described on CMS' Plan Reporting and Oversight webpage and on CMS' Program Audits webpage.

For 20201001 BOD Review Only

IV. ATTACHMENT(S)

A. Medicare Prescription Drug Coverage and Your Rights (OneCare) IR19_PD036_H5433
B. Medicare Prescription Drug Coverage and Your Rights (OneCare Connect) H8016_PD16_30
C. Notice of Case Status (OneCare) H5433_PD17_21
D. Notice of Case Status (OneCare Connect) H8016_PD17_20
E. Form 1696: Appointment of Representative Form

V. REFERENCE(S)

A. Applications from Medicare Advantage Prescription Drug Plans (MA-PD) Sponsors
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Policy MA.2001: Marketing Material Standards
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. Health and Safety Code, § 1367.01
F. Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, ~~Released February 2019~~Effective January 1, 2020.
G. Social Security Act, §§ 1860D-2, D-43, and 1862
H. Title 42, Code of Federal Regulations (C.F.R.), Part 423, Subpart M

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2006	MA.6101	Coverage Determination	OneCare
Revised	03/01/2007	MA.6101	Coverage Determination	OneCare
Revised	07/01/2007	MA.6101	Coverage Determination	OneCare
Revised	10/01/2012	MA.6101	Coverage Determination	OneCare
Revised	03/01/2013	MA.6101	Coverage Determination	OneCare
Revised	01/01/2014	MA.6101	Coverage Determination	OneCare
Revised	03/01/2014	MA.6101	Coverage Determination	OneCare
Revised	06/01/2015	MA.6101	Coverage Determination	OneCare OneCare Connect
Revised	03/01/2017	MA.6101	Coverage Determination	OneCare OneCare Connect
Revised	04/01/2018	MA.6101	Coverage Determination	OneCare OneCare Connect
Revised	10/01/2018	MA.6101	Coverage Determination	OneCare OneCare Connect
Revised	08/01/2019	MA.6101	Coverage Determination	OneCare OneCare Connect
Revised	TBD	MA.6101	Coverage Determination	OneCare OneCare Connect

For 2020 1001 BOD Review Only

1

For 20201001 BOD Review Only

IX. GLOSSARY

Term	Definition
Appeal	Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review.
Authorized Representative	An individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a grievance, requesting a coverage determination, or in dealing with any level of the appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423, Subpart M, the representative has all of the rights and responsibilities of a Member in obtaining a coverage determination or in dealing with any of the levels of the appeals process, subject to the rules described in Part 422, Subpart M.
Cash Purchase	A Member's purchase of a covered drug without using their CalOptima benefits.
Controlled Medication	A prescription drug that is regulated by the Drug Enforcement Administration (DEA) based on its currently accepted medical use in treatment in the United States, its relative abuse potential, and its likelihood of causing dependence when abused.
Coverage Determination (CD)	Any decision made by CalOptima regarding: 1. Receipt of, or payment for, a prescription drug that a Member believes may be covered; 2. A tiering or Formulary Exception request; 3. The amount that the plan sponsor requires a Member to pay for a Part D prescription drug and the Member disagrees with the plan sponsor; 4. A limit on the quantity (or dose) of a requested drug and the Member disagrees with the requirement or dosage limitation; 5. A requirement that a Member try another drug before the plan sponsor will pay for the requested drug and the Member disagrees with the requirement; and 6. A decision whether a Member has, or has not, satisfied a Prior Authorization or other Utilization Management requirement.
Covered Part D Drug	A Covered Part D Drug includes: 1. A drug that may be dispensed only upon a Prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically accepted indication as set forth in Section 1927(k)(2)(A) of the Social Security Act; 2. A biological product described in Sections 1927(k)(2)(B)(i) through (iii) of the Social Security Act; 3. Insulin described in Section 1927(k)(2)(C) of the Social Security Act; 4. Medical supplies associated with the delivery of insulin; and 5. A vaccine licensed under Section 351 of the Public Health Service Act and its administration.

For 20201001 BOD Review Only

Term	Definition
Deferral	Extending the timeframe for review of a standard or expedited prospective request for a Medi-Cal Additional Demonstration Drug (ADD) when the extension is requested or justified.
Exception	An Exception is a type of coverage determination. An Exception is a request for coverage for a drug that is not normally on the Formulary (list of covered drugs), or to use the drug without certain rules and limitations.
Formulary	The approved list of outpatient medications, medical supplies and devices, and the Utilization Management Protocols as approved by the CalOptima Pharmacy & Therapeutics (P&T) Committee for prescribing to Members.
Formulary Exception	A Formulary Exception is a type of coverage determination. A Formulary Exception is a request to obtain a drug that is not included on CalOptima's Formulary or to obtain a Formulary drug that is subject to a Utilization Management restriction (e.g., Step Therapy, Prior Authorization, Quantity Limit) which the requestor believes should not apply.
Independent Review Entity (IRE)	An independent entity contracted by CMS to review Part D plan sponsor denials of coverage determinations.
Medically Necessary or Medical Necessity ~~Services~~	OneCare: Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. OneCare Connect: Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	A ~~Member~~ beneficiary ~~of~~enrolled in a CalOptima program.~~A Part D eligible individual who has elected OneCare or OneCare Connect.~~
Non-Exception	A Non-Exception is a type of coverage determination. A Non-Exception is a request for coverage for a drug that is included on CalOptima's Formulary subject to a Utilization Management restriction (e.g. Step Therapy, Prior Authorization, Quantity Limit), and the requestor is attempting to satisfy the requirements for coverage.
Participating Pharmacy	Any Pharmacy that is credentialed by, and contracted with, the Pharmacy Benefit Manager (PBM) to provide Pharmaceutical Services to Members.
Pharmacy Benefits Manager (PBM)	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and Prior Authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.
Prescriber	A healthcare professional who is authorized under State law or other applicable law to write prescriptions.
Prescriber Supporting Statement	A statement of medical justification consistent with the requirements set forth in Title 42 of the Code of Federal Regulations, Section 423.578(b)(5).

For 20201001 BOD Review Only

Term	Definition
	An oral or written supporting statement, provided by the Prescriber, that the requested prescription drug is Medically Necessary to treat the Member's disease or medical condition because— (i) All of the Covered Part D Drugs on any tier of the Formulary for treatment for the same condition would not be as effective for the Member as the non-Formulary drug, would have adverse effects for the Member, or both; (ii) The prescription drug alternative(s) listed on the Formulary or required to be used in accordance with Step Therapy requirements— (A) Has been ineffective in the treatment of the Member's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence and the known relevant physical or mental characteristics of the Member and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or (B) Has caused or based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the Member; or (iii) The number of doses that is available under a dose restriction for the prescription drug has been ineffective in the treatment of the Member's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence and the known relevant physical or mental characteristics of the Member and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
Prior Authorization (PA)	The Formulary restriction which requires approval from CalOptima before the requested medication is covered.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.
Quantity Limit (QL)	The Formulary restriction which limits the amount of the requested medication that CalOptima will cover.
Redetermination (RD) (Pharmacy)	The first level of the appeal process, which involves a Part D plan sponsor reevaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.
Step Therapy (ST)	The Formulary restriction which requires an enrollee to first try certain drugs to treat a medical condition before the requested medication is covered.
Tiering Exception	A Tiering Exception is a type of coverage determination. A Tiering Exception is a request to obtain a non-preferred drug in a higher cost-sharing tier at the lower cost-sharing terms applicable to drugs in a lower cost-sharing tier.
Tolling	Extending the timeframe for review of a standard or expedited Formulary or Tiering Exception for a Covered Part D Drug when a Prescriber Supporting Statement has not been received.
Utilization Management (UM)	Requirements or limits on coverage. Utilization Management may include, but is not limited to, Prior Authorization, Quantity Limit, or Step Therapy restrictions.

1

For 20201001 BOD Review Only

Policy:	MA.6101
Title:	**Medicare Part D Coverage Determination**
Department:	Medical Management
Section:	Pharmacy Management
CEO Approval:	
Effective Date:	01/01/2006
Revised Date:	
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

For 20201001 BOD Review Only

I. PURPOSE

This policy describes CalOptima's process for determination of drug benefit coverage and/or payment of drug benefits for Medicare Part D.

II. POLICY

A. A Coverage Determination (CD) is any determination (i.e., an approval or denial) made by CalOptima with respect to the following:

1. A decision about whether to provide or pay for a drug that the Member believes may be covered by CalOptima, including a decision not to pay because:

   a. The drug is not on the plan's Formulary,

   b. The drug is determined not to be Medically Necessary,

   c. The drug is furnished by an out-of-network pharmacy, or

   d. The drug is otherwise excluded under Medicare Part D, Medicare Part B, and/or Medi-Cal.

2. Failure to provide a CD in a timely manner, when a delay would adversely affect the health of the Member;

3. A decision concerning a Tiering Exceptions request under Title 42 of the Code of Federal Regulations, Section 423.578(a);

4. A decision concerning a Formulary Exceptions request under Title 42 of the Code of Federal Regulations, Section 423.578(b);

5. A decision on the amount of cost-sharing for a drug; or

6. A decision whether a Member has, or has not, satisfied a Prior Authorization or other Utilization Management requirement.

B. Who May Request a Coverage Determination (CD)

Back to Agenda Back to Item

1. Medicare Part D requests for coverage may be made by a Member, a Member's Prescriber or staff of Prescriber's office acting on the Prescriber's behalf, or a Member's Authorized Representative.

C. With respect to CDs, a Member shall have the following rights:

1. The right to a timely decision;

2. The right to an expedited decision, subject to the provisions of this policy;

3. The right to receive written notice of Tolling;

4. The right to receive detailed written notice of CalOptima's decision;

5. The right to request and receive Appeal data from CalOptima;

6. The right to receive notice when a request is forwarded to the Independent Review Entity (IRE); and

7. The right to a reconsideration by the IRE.

D. Subject to the provisions of this policy, a Member, a Member's Authorized Representative, or a Member's Prescriber may request a Medicare Part D Exception under the following circumstances:

1. To obtain a non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier;

2. The requested drug regimen exceeds CalOptima limitations for quantity, refill frequency, duration of therapy, or does not meet Step Therapy restrictions;

3. The requested drug is not on the Formulary; or

4. To waive a Prior Authorization (PA) or other Utilization Management (UM) requirement.

E. A request for a Medicare Part D Formulary Exception will require the Member's Prescriber to provide medical justification or a supporting statement consistent with the requirements set forth in Title 42 of the Code of Federal Regulations, Section 423.578(b)(5).

F. CalOptima shall make a CD within the time frames defined within this Policy.

1. If additional information is required, CalOptima shall make reasonable and diligent efforts to obtain the necessary information within the defined time frames from sources which may include, but are not limited to, the Prescriber, the Member, and other healthcare Providers.

2. If the necessary information is not available within the defined time frames, CalOptima shall make its determination based upon the evidence that exists, if any.

3. If a Medicare Part D CD is not made within the defined time frames, CalOptima shall auto-forward the request to the IRE.

G. CalOptima shall accept CD requests, Exception requests, and Prescriber Supporting Statements in the following formats:

For 20201001 BOD Review Only

1. Telephone;

2. Mail;

3. Facsimile; and

4. CalOptima website.

5. A CD request which involves direct payment or reimbursement to the Member shall only be accepted in writing.

6. CalOptima shall not require a written request or a supporting statement to be provided on a specific form.

H. Subject to the provisions of this Policy, CalOptima shall notify a Member, a Member's Authorized Representative, a Member's Prescriber, and a Member's Provider of services of the CD outcome in writing and, in some cases, orally.

I. CalOptima's Medical Director shall be responsible for ensuring the clinical accuracy of all Coverage Determinations involving Medical Necessity. The Medical Director shall be a physician with a current license to practice medicine in the state of California.

1. A physician or other appropriate health care professional with sufficient medical expertise and knowledge of coverage criteria shall review partially or fully adverse Medical Necessity CD decisions. The physician or other health care professional must have a current and unrestricted license to practice within the scope of his or her profession in the state of California.

2. A pharmacist is considered an appropriate health care professional for purposes of meeting this requirement.

J. Member Notification

1. CalOptima shall maintain a List of Covered Drugs (Formulary), including restrictions such as Quantity Limit (QL), Prior Authorization (PA), and Step Therapy (ST) requirements, and shall make the Formulary available to Members on its Website. Members may also request a mailed copy of the Formulary.

2. CalOptima shall provide Members with information about the CD process, including how to contact CalOptima, in the Evidence of Coverage and Member Handbook.

3. All Member-facing materials shall be reviewed and approved by CMS, consistent with CalOptima Policy MA.2001: Marketing Material Standards.

III. PROCEDURE

A. When a claim for a potentially Part D drug rejects at the pharmacy point of service (POS) with an electronic notice indicating that the drug is subject to a PA or other UM requirement, the POS pharmacist or other pharmacy personnel shall provide the Member with the standardized Form CMS-10147, Medicare Prescription Drug Coverage and Your Rights.

B. Requesting a Coverage Determination (CD)

For 2020 1001 BOD Review Only

1. A Member, a Member's Authorized Representative, a Member's Prescriber, , or a Provider of health care services for the Member, as described in Section II.B of this Policy, may submit a CD request orally, or in writing, indicating the request to be either "standard" or "expedited."

    a. A Member's Authorized Representative shall submit a valid signed Form CMS-1696 or other equivalent notice to CalOptima.

    b. CalOptima shall include a copy of the original signed Form CMS-1696 or other equivalent notice or conforming written instrument with each new request for a Coverage Determination.

    c. CalOptima shall not require the Member to sign a new form for the life of the Coverage Determination, or for any new Coverage Determination filed by the Authorized Representative within one (1) calendar year from the date that a valid form was executed.

2. A CD request for services that have already been furnished:

    a. Shall not be expedited.

    b. Shall be accepted only in written formats when direct payment to the Member is also requested.

C. Requesting an Expedited CD

1. A Member, a Member's Authorized Representative, a Member's Prescriber, or a Provider of health care services for the Member, as described in Section II.B of this policy, may request CalOptima to expedite a CD if waiting for a standard CD may seriously jeopardize the Member's life, health, or ability to regain maximum function.

2. CalOptima shall not accept any request to expedite a CD for drugs already furnished to the Member.

3. CalOptima shall provide an expedited CD if:

    a. A request to expedite is made or supported by a Prescriber and the Prescriber indicates, either orally or in writing, that applying the standard time for making a determination may seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function; or

    b. A request to expedite is made by a Member or Member's Authorized Representative and CalOptima finds that the Member's health, life, or ability to regain maximum function may be seriously jeopardized by waiting for a standard CD.

4. If CalOptima denies a request to expedite a CD, CalOptima shall proceed as follows:

    a. Transfer and process the request under the standard CD procedures as set forth in this policy.

    b. Provide the Member or Member's Authorized Representative and the Prescriber with prompt verbal notice of the denial that:

        i. Explains that CalOptima shall process the request within the standard CD timeframe;

For 20201001 BOD Review Only

Back to Agenda Back to Item

ii. Informs the Member of the right to file an expedited grievance if he or she disagrees with CalOptima's decision not to expedite the CD;

iii. Informs the Member of the right to resubmit a request for an expedited CD with the Prescriber's support; and

iv. Provides instructions about CalOptima's expedited grievance process and time frames.

c. Deliver a written notice, equivalent to the oral notice described in Section III.C.4.b of this Policy, to the Member or Member's Authorized Representative and the Prescriber within three (3) calendar days after providing verbal notice.

D. If CalOptima makes a fully or partially favorable decision:

1. CalOptima shall effectuate the authorization retroactive to the date of the first request made during the contract year, or retroactive to the date of service indicated in the request, whichever comes earlier.

2. For an Exception request, the coverage duration of the approval shall be for the remainder of the contract year.

3. For a Non-Exception request, the coverage duration of the approval shall be consistent with the duration specified in the Formulary Prior Authorization criteria as calculated based on the date the decision is made. If the criteria does not specify the coverage duration, then the coverage duration shall be for the remainder of the plan year.

4. The coverage duration applies so long as:

a. The Prescriber continues to prescribe the drug; and

b. The drug continues to be considered safe for treating the Member's disease or medical conditions; and

c. The Member's enrollment period has not expired.

5. CalOptima shall not require the Member to request approval for a refill or a new prescription to continue using the approved drug after the refills for the initial prescription are exhausted, subject to the provisions of this policy.

6. CalOptima shall provide notification to the Member or the Member's Authorized Representative and the Prescriber (as applicable), as described in Section III.M. of this Policy.

E. If CalOptima makes a fully or partially unfavorable decision, CalOptima shall provide notification to the Member or the Member's Authorized Representative and the Prescriber (as applicable), as described in Section III.M. of this Policy.

F. Requesting a Tiering Exception

1. A request for an Exception to CalOptima's tiered cost-sharing structure (Tiering Exception) shall include an oral or written supporting statement from the Prescriber that the drug in the lower cost-sharing tier for treatment of the Member's condition:
   a. Would not be as effective as the requested drug in the higher cost-sharing tier;

For 20201001 BOD Review Only

b. Would have adverse effects; or

c. Both of the above.

2. CalOptima is not required to approve a Tiering Exception for a drug in a higher cost-sharing tier at the generic tier cost-sharing level as long as CalOptima maintains a separate tier that only includes generic drugs as defined in Title 42 of the Code of Federal Regulations.

3. Under Title 42 of the Code of Federal Regulations, Section 423.578(c)(4)(iii), a Tiering Exception may not be requested for a Non-Formulary drug approved under the Formulary Exception process.

4. CalOptima shall grant a Tiering Exception if it determines that the drug in the lower cost-sharing tier for treatment of the Member's condition would not be as effective for the Member as the requested drug and/or would have adverse effects.

G. Requesting a Formulary Exception

1. A request for a Formulary Exception to obtain a Covered Part D Drug that is not included on CalOptima's Formulary shall include an oral or written supporting statement from the Prescriber documenting that the requested drug is Medically Necessary to treat the Member's disease or medical condition because all Covered Part D Drugs on any tier of the CalOptima Formulary for treatment of the same condition:

a. Would not be as effective for the Member as the requested drug;

b. Would have adverse effects for the Member; or

c. Both of the above.

2. A request for a Formulary Exception to obtain a Covered Part D Drug that is included on CalOptima's Formulary and subject to a Step Therapy restriction which the requestor believes should not apply shall include an oral or written supporting statement from the Prescriber documenting that the requested drug is Medically Necessary to treat the Member's disease or medical condition because the prescription drug alternative(s) listed on the Formulary:

a. Has been ineffective in the treatment of the Member's disease or medical condition; or

b. Based on sound clinical and medical and scientific evidence, and the known relevant physical or mental characteristics of the Member, and the known characteristics of the drug regimen, it is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

3. A request for a Formulary Exception to obtain a Covered Part D Drug that is included on CalOptima's Formulary and subject to a Quantity Limit restriction which the requestor believes should not apply shall include an oral or written supporting statement from the Prescriber documenting that the requested drug is Medically Necessary to treat the Member's disease or medical condition because the number of doses available under a dose restriction (Quantity Limit) for the prescription drug:

a. Has been ineffective in the treatment of the Member's disease or medical condition; or

For 20201001 BOD Review Only

b. Based on sound clinical, medical, and scientific evidence, and the known relevant physical or mental characteristics of the Member, and the known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

4. A request for a Formulary Exception to obtain a Covered Part D Drug that is included on CalOptima's Formulary and subject to a Prior Authorization restriction, which the requestor believes should not apply, shall include an oral or written supporting statement from the Prescriber documenting that:

   a. The requested drug is Medically Necessary to treat the Member's disease or medical condition; and

   b. The Member would suffer adverse effects if he or she were required to satisfy the PA requirement.

5. Under Title 42 of the Code of Federal Regulations, Section 423.578(f), nothing in the regulations or in this Policy should be construed to mean that the Prescriber's Supporting Statement will result in an automatic favorable determination.

6. CalOptima may grant a Formulary Exception request if it determines that:

   a. The requested drug is Medically Necessary, based on the physician's or other Prescriber's supporting statement; and

   b. CalOptima determines that all Covered Part D Drugs on any tier of the Formulary for treatment of the same condition:

      i. May not be as effective for the Member as the requested drug;

      ii. May have adverse effects for the Member; or

      iii. Both of the above.

7. If CalOptima approves a Formulary Exception request to obtain a Covered Part D Drug:

   a. The cost-sharing tier for the approved drug under the Formulary Exceptions process shall be:

      i. Equivalent to the higher cost-sharing tier for all brand name drugs; or

      ii. Equivalent to the lower cost-sharing tier for all generic drugs.

   b. CalOptima may choose not to require the Member to resubmit a Formulary Exception request at the beginning of a new plan year. CalOptima may auto-extend Formulary Exception approvals for the following year on a case-by-case basis. If applicable, Members will be notified with an approval letter indicating the new expiration date.

H. Requesting Retrospective Coverage and Payment Reimbursement for a Cash Purchase

1. Any decision made by CalOptima about reimbursing a Member for a drug and any decision to reimburse the Member for all or part of a cost-sharing amount is a CD.

For 20201001 BOD Review Only

Back to Agenda Back to Item

2. A request for reimbursement shall be made in writing by one (1) of the individuals described in Section II.B of this Policy.

3. CalOptima shall accept a CD for payment reimbursement for a drug.

   a. CalOptima's Prescription Drugs Payment Request Form may be used to request reimbursement, but shall not be required.

   b. Copies of prescriptions and receipts may be included with a reimbursement request, but shall not be required.

4. When a reimbursement request must be resolved under the Formulary or Tiering Exceptions process, CalOptima shall not toll the timeframe.

5. If CalOptima does not have all the information needed to make a decision, reasonable and diligent efforts shall be made to obtain the missing information within the time frames described in Section III.K. of this Policy.

6. CalOptima shall make a CD for a drug dispensed as a Cash Purchase at a Non-Participating Pharmacy if:

   a. CalOptima cannot reasonably expect the Member to obtain such drugs at a Participating Pharmacy in a timely manner; and

   b. The Member does not access covered drugs at non-Participating Pharmacies on a routine basis.

   c. For purposes of this policy, accessing covered drugs at a Non-Participating Pharmacy on a routine basis shall be construed to mean more than one occurrence per drug per twelve (12)-month period.

7. CalOptima shall make a CD for a drug dispensed as a Cash Purchase at a Participating Pharmacy if the circumstances for the Cash Purchase are reasonable, such as:

   a. When the Pharmacy's or CalOptima's PBM's system is down;

   b. When a family Member or other person who is filling a prescription on the Member's behalf does not have the Member's benefit card and the Member is not in the Pharmacy's system;

   c. When the Pharmacy or CalOptima's PBM mistakenly charge the Member for the drug; or

   d. The prescription was written in connection with a medical emergency or urgent care.

8. If a Member accesses a Covered Part D Drug as a Cash Purchase, the Member may be required to pay the out-of-network differential (that is, the difference between the Non-Participating Pharmacy's usual and customary (U&C) price and CalOptima's negotiated rate for such Covered Part D Drug) if the conditions in Section III.H.6 and III.H.7 are not met.

9. The Member shall be required to pay their applicable cost-sharing.

I. Request for CD for Medicare Part B versus Medicare Part D Drugs

For 20201001 BOD Review Only

1. CalOptima shall not consider a drug prescribed to a Member a Covered Part D Drug if payment for such drug is available (or would be available but for the application of a deductible) under Medicare Part A or Medicare Part B for that Member.

2. CalOptima relies on the point of service pharmacy to communicate to CalOptima the diagnosis provided by the Prescriber to determine whether benefit coverage is required for select covered drugs.

    a. In determining drug coverage under Medicare Part D versus Medicare Part B, CalOptima accepts diagnoses documented on the face of the prescription.

    b. Nebulized Inhalation Drugs: If the patient residence code is "3", or "9" indicating the Member is in a Nursing Facility or Intermediate Care Facility, then inhalation drugs used with a nebulizer are Medicare Part D benefits. Inhalation drugs are covered under Medicare Part B when used with a nebulizer in the home.

    c. Oral Anti-Cancer Drugs: Certain oral chemotherapy agents used in cancer treatment are covered by Medicare Part B, as determined by CMS.

    d. Immunosuppressive Drugs: Drugs used in immunosuppressive therapy for a Member who has received a Medicare covered organ transplant are covered under Medicare Part B; else these drugs are likely used for auto-immune conditions and are covered by Medicare Part D benefits.

    e. Drugs for Dialysis-Related Conditions: Drugs used for renal dialysis-related conditions for Member receiving renal dialysis services may have a point of service PA requirement to determine if payment is included in the Medicare Part B bundled payment to a dialysis facility.

    f. In institutional settings, CalOptima will also accept diagnoses documented in the medical record by the Prescriber.

    g. The point of service Pharmacy's communication of the diagnosis to CalOptima or CalOptima's PBM Help Desk may enable the Pharmacy to receive an immediate override for the applicable benefit when the diagnosis supports coverage under Medicare Part B or Medicare Part D.

3. Daily on business days, CalOptima shall identify all new pharmacy claim rejections for immunosuppressive drugs for the purpose of making an administrative prospective payment determination.

    a. CalOptima shall contact the Member's Pharmacy, the Member's Prescriber, and/or the Member to collect pertinent medical history and diagnosis.

    b. Administrative prospective payment determinations shall be made within one (1) business day of identification of the rejected claim.

    c. An administrative prospective payment determination shall not be treated as a request for CD.

4. If CalOptima determines that the diagnosis is not consistent with Medicare Part D coverage, the request shall be denied as not meeting the definition of a Covered Part D Drug.

For 2020 1001 BOD Review Only

Back to Agenda Back to Item

a. The Member or the Member's Authorized Representative and the Prescriber shall receive a Notice of Denial of Medicare Prescription Drug Coverage.

b. The Notice of Denial of Medicare Prescription Drug Coverage shall provide an explanation of the conditions of approval as a Medicare Part B Drug.

c. An administrative prospective payment determination of Medicare Part B versus Medicare Part D shall not be subject to CD requirements.

J. Time Frames for Completing Coverage Determinations

1. Standard Prospective Request

a. CalOptima shall complete the CD, notify the Member or Member's Authorized Representative and the Prescriber, and effectuate the decision, if applicable, as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after the date and time CalOptima received the request or, if the request involves a Formulary or Tiering Exception, the date and time CalOptima received the Prescriber's Supporting Statement.

2. Expedited Prospective Request

a. CalOptima shall complete the CD, notify the Member or Member's Authorized Representative and the Prescriber, and effectuate the decision, if applicable, as expeditiously as the Member's health condition requires, but no later than twenty-four (24) hours after the date and time CalOptima received the request or, if the request involves a Formulary or Tiering Exception, the date and time CalOptima received the Prescriber's Supporting Statement.

3. Retrospective Request

a. A retrospective request that does not involve direct payment to the Member shall be resolved under the procedures for standard prospective requests as described in this policy.

b. For a retrospective request involving direct payment to the Member, CalOptima shall complete the CD, notify the Member or Member's Authorized Representative and the Prescriber, and effectuate the decision, if applicable, no later than fourteen (14) calendar days after the date and time CalOptima received the request.

4. Time Frame Extension

a. Tolling a Medicare Part D Request for a Formulary or Tiering Exception

i. CalOptima shall not keep an Exception request open indefinitely if the Prescriber does not submit a supporting statement for the Medical Necessity of the requested drug.

ii. For standard and expedited prospective Exception requests, CalOptima shall toll the Exception request for up to seven (7)calendar days and make a CD at the end of the Tolling period with the best available information.

iii. CalOptima shall provide written notification to the Member when a Part D Exception request is tolled to obtain a Prescriber Supporting Statement.

For 20201001 BOD Review Only

Back to Agenda Back to Item

iv. Tolling shall not apply for Non-Exception requests.

v. Tolling shall not apply for retrospective payment requests.

5. Auto-forward

a. If CalOptima does not make a decision, or fails to provide notice of the decision, in the applicable timeframe, then within twenty-four (24) hours of the expiration of the adjudication time frame CalOptima shall:

i. Forward the request and case file to the Independent Review Entity (IRE) for review; and

ii. Notify the Member that the decision was not made timely and that their request is being forwarded to the IRE, utilizing the "Notice of Case Status" instead of Form CMS-10146: Notice of Denial of Medicare Prescription Drug Coverage.

iii. If CalOptima discovers the untimely decision or notification more than twenty-four (24) hours after the expiration of the adjudication time frame, then CalOptima shall forward the request to the IRE and provide the Member with the "Notice of Case Status" as quickly as possible, not to exceed one (1) business day after discovery.

iv. If CalOptima's decision was fully favorable and was made soon after the expiration of the adjudication time frame (within one (1) business day), then CalOptima shall not forward the request to the IRE nor provide the Member with the "Notice of Case Status."

K. Request for Additional Information

1. When CalOptima does not have all the information needed to make a coverage decision, CalOptima shall make reasonable and diligent efforts to obtain all necessary information, including medical records and other pertinent documentation, from the Member's Prescriber.

2. CalOptima shall make a minimum of one (1) attempt to obtain additional information within the applicable adjudication time frame. However, when possible, CalOptima shall use multiple means of communication, including:

a. Telephone;

b. Fax;

c. E-mail; and/or

d. Standard or overnight mail with certified return receipt.

3. The sufficiency of CalOptima's outreach efforts are determined on a case-by-case basis and are contingent upon the facts and circumstances of each case.

4. CalOptima shall document all requests for information and maintain that information with the case file. The documentation must include:

a. A specific description of the required information;

For 20201001 BOD Review Only

b. The name, phone number, fax number, e-mail and/or mailing address, as applicable, for the point of contact at CalOptima; and

c. The date and time of each request, documented by date and time stamps on copies of a written request, call record, facsimile transmission, or e-mail. Call records should include specific information about who was contacted, what was discussed/requested, and what information was obtained by CalOptima.

5. Requests for information shall be made in a manner that increases the likelihood of making contact with the Prescriber and receiving the information.

a. When possible, requests for additional information shall be made during normal business hours in the Prescriber's time zone. However, outreach must not be limited to business hours when the time frame is limited.

b. CalOptima shall leverage its contractual relationship when the request involves the need for information from a contracted Provider.

6. The first request for information shall be made within the time frames indicated in the table below.

➔ **Priority**	**Standard Request**	**Expedited Request**
Medicare Part D	Twenty-Four (24) Hours	Upon Receipt

7. When deemed necessary on a case-by-case basis, network Prescribers who do not respond to requests for required additional information may be referred to CalOptima's Medical Director for review.

L. Refill Too Soon

1. CalOptima may grant an override for an early refill as an administrative override and will not require a CD.

a. A vacation supply of up to ninety (90) calendar days may be granted at a frequency of one (1) override per calendar year per medication.

b. A replacement supply of lost, stolen, or damaged medication may be granted at a frequency of one (1) override per calendar year per medication for a quantity up to the amount dispensed for the lost, stolen, or damaged medication prescription.

2. On a case-by-case basis, CalOptima may initiate a CD for an early refill request which exceeds one (1) request per medication per calendar year.

3. When the early refill request is for a Controlled Medication, CalOptima may require a CD and may require additional information on a case-by-case basis, as indicated by the facts and circumstances of each case, such as:

a. Prescriber approval;

b. Documentation to support the Member's reason for the request; and/or

c. A police report.

For 20201001 BOD Review Only

M. Notification Standards

1. Written notification of a fully favorable decision must be written in a manner that is understandable to the Member and explain the conditions of the approval, including (but not limited to):

   a. The duration of an approval;

   b. Limitations associated with an approval; and/or

   c. Any coverage rules applicable to subsequent refills.

2. Written notification of a fully or partially unfavorable decision must be specific to each individual case, written in a manner that is understandable to the Member, and provide:

   a. The specific reason for the denial that takes into account the Member's presenting medical condition, disabilities, and special language requirements, if any;

   b. A description of any applicable Medicare coverage rule or any other applicable Part D plan policy upon which the denial decision was based, including the type of information that should be submitted when seeking a Formulary or Tiering Exception, if applicable;

   c. Information regarding the right to appoint a representative to file an Appeal on the Member's behalf; and

   d. A description of the standard and expedited Redetermination processes and time frames.

3. Written notification is required for all unfavorable decisions (fully or partially unfavorable) pertaining to Medicare Part D.

4. Written notification is required for fully favorable decisions pertaining to Medicare Part D benefits.

5. CalOptima may make its initial notification orally so long as it also mails a written follow-up decision within three (3) calendar days of the oral notification. However, if a good faith effort was made but CalOptima is not able to provide verbal notice, written follow-up decision will be sent within the applicable adjudication timeframe. Oral notifications must satisfy the same requirements as written notifications, as described in Sections III.M.1 and III.M.2. of this Policy.

6. When CalOptima has the Member's telephone number on file and relies on it to provide oral notice, but is unable to reach the Member because it is either incorrect, out-of-service, or no person (or no voicemail system) answers, its good-faith effort to provide oral notice satisfies the notification requirement if:

   a. The good-faith effort is documented in writing and included in the case file,

   b. Written notice of the decision is sent to the Member within the adjudication timeframe.

7. When the Member's telephone number and/or mailing address is invalid or missing, CalOptima, or its downstream delegated entities, shall make a reasonable and diligent effort to obtain it,

For 20211001 BOD Review Only

such as outreach to the Prescriber and/or dispensing pharmacy, if known, to request it. The outreach efforts shall be documented in writing and included in the case file.

8. Written notification to the Prescriber, as applicable, shall be communicated via facsimile.

   a. CalOptima or its delegated downstream entities shall document a copy of the notice, the date and time of facsimile transmission, and the final processing status of the transmission (successful or failed) in the case file.

   b. If the facsimile transmission is not successful, CalOptima or its delegated downstream entity shall attempt to re-send the facsimile and/or outreach to the Prescriber to obtain a working fax number and provide verbal notification of the decision.

9. Written notification to the Member or Member's Authorized Representative, as applicable, shall be communicated via postal mail. Letters shall be mailed in accordance with the delegated downstream entity and/or CalOptima facility mailing procedures.

10. Notification of the results of the Medicare Part D CD shall be provided to the Member, the Member's Authorized Representative, and/or the Member's Prescriber as indicated in the table below.

➔ **Requestor** 🡻 **Notification to…**	**Member**	**Member's Representative**	**Member's Prescriber**
Member	Required	Optional	Required
Member's Representative	Optional	Required	Optional
Member's Prescriber	Optional	Optional	Required (written notice is not required if oral notice is provided)

N. Documentation and Reporting

1. CalOptima's Customer Service Department shall track oral CD requests made by a Member or the Member's Authorized Representative in CalOptima's core system. CalOptima's Customer Service Department shall document in the core system, at a minimum, the date of receipt of a request for a CD.

2. CalOptima's Pharmacy Management Department shall track written CD requests made by a Member or Member's Authorized Representative in the PBM's Prior Authorization Database.

3. CalOptima's Pharmacy Management Department and delegated downstream entities shall track oral and written CD requests made by Prescribers and other Providers in the PBM's Prior Authorization Database.

4. CalOptima is responsible for reporting certain data related to CD requests, as described on CMS' Plan Reporting and Oversight webpage and on CMS' Program Audits webpage.

IV. ATTACHMENT(S)

A. Medicare Prescription Drug Coverage and Your Rights (OneCare) IR19_PD036_H5433
B. Medicare Prescription Drug Coverage and Your Rights (OneCare Connect) H8016_PD16_30
C. Notice of Case Status (OneCare) H5433_PD17_21

For 2020 1001 BOD Review Only

D. Notice of Case Status (OneCare Connect) H8016_PD17_20
E. Form 1696: Appointment of Representative Form

V. REFERENCE(S)

A. Applications from Medicare Advantage Prescription Drug Plans (MA-PD) Sponsors
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Policy MA.2001: Marketing Material Standards
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. Health and Safety Code, § 1367.01
F. Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Effective January 1, 2020.
G. Social Security Act, §§ 1860D-2, D-43, and 1862
H. Title 42, Code of Federal Regulations (C.F.R.), Part 423, Subpart M

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2006	MA.6101	Coverage Determination	OneCare
Revised	03/01/2007	MA.6101	Coverage Determination	OneCare
Revised	07/01/2007	MA.6101	Coverage Determination	OneCare
Revised	10/01/2012	MA.6101	Coverage Determination	OneCare
Revised	03/01/2013	MA.6101	Coverage Determination	OneCare
Revised	01/01/2014	MA.6101	Coverage Determination	OneCare
Revised	03/01/2014	MA.6101	Coverage Determination	OneCare
Revised	06/01/2015	MA.6101	Coverage Determination	OneCare OneCare Connect
Revised	03/01/2017	MA.6101	Coverage Determination	OneCare OneCare Connect
Revised	04/01/2018	MA.6101	Coverage Determination	OneCare OneCare Connect
Revised	10/01/2018	MA.6101	Coverage Determination	OneCare OneCare Connect
Revised	08/01/2019	MA.6101	Coverage Determination	OneCare OneCare Connect
Revised	TBD	MA.6101	Coverage Determination	OneCare OneCare Connect

For 2020 10/01 BOD Review Only

IX. GLOSSARY

Term	Definition
Appeal	Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review.
Authorized Representative	An individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a grievance, requesting a coverage determination, or in dealing with any level of the appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423, Subpart M, the representative has all of the rights and responsibilities of a Member in obtaining a coverage determination or in dealing with any of the levels of the appeals process, subject to the rules described in Part 422, Subpart M.
Cash Purchase	A Member's purchase of a covered drug without using their CalOptima benefits.
Controlled Medication	A prescription drug that is regulated by the Drug Enforcement Administration (DEA) based on its currently accepted medical use in treatment in the United States, its relative abuse potential, and its likelihood of causing dependence when abused.
Coverage Determination (CD)	Any decision made by CalOptima regarding: 1. Receipt of, or payment for, a prescription drug that a Member believes may be covered; 2. A tiering or Formulary Exception request; 3. The amount that the plan sponsor requires a Member to pay for a Part D prescription drug and the Member disagrees with the plan sponsor; 4. A limit on the quantity (or dose) of a requested drug and the Member disagrees with the requirement or dosage limitation; 5. A requirement that a Member try another drug before the plan sponsor will pay for the requested drug and the Member disagrees with the requirement; and 6. A decision whether a Member has, or has not, satisfied a Prior Authorization or other Utilization Management requirement.
Covered Part D Drug	A Covered Part D Drug includes: 1. A drug that may be dispensed only upon a Prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically accepted indication as set forth in Section 1927(k)(2)(A) of the Social Security Act; 2. A biological product described in Sections 1927(k)(2)(B)(i) through (iii) of the Social Security Act; 3. Insulin described in Section 1927(k)(2)(C) of the Social Security Act; 4. Medical supplies associated with the delivery of insulin; and 5. A vaccine licensed under Section 351 of the Public Health Service Act and its administration.

For 20201001 BOD Review Only

Term	Definition
Deferral	Extending the timeframe for review of a standard or expedited prospective request for a Medi-Cal Additional Demonstration Drug (ADD) when the extension is requested or justified.
Exception	An Exception is a type of coverage determination. An Exception is a request for coverage for a drug that is not normally on the Formulary (list of covered drugs), or to use the drug without certain rules and limitations.
Formulary	The approved list of outpatient medications, medical supplies and devices, and the Utilization Management Protocols as approved by the CalOptima Pharmacy & Therapeutics (P&T) Committee for prescribing to Members.
Formulary Exception	A Formulary Exception is a type of coverage determination. A Formulary Exception is a request to obtain a drug that is not included on CalOptima's Formulary or to obtain a Formulary drug that is subject to a Utilization Management restriction (e.g., Step Therapy, Prior Authorization, Quantity Limit) which the requestor believes should not apply.
Independent Review Entity (IRE)	An independent entity contracted by CMS to review Part D plan sponsor denials of coverage determinations.
Medically Necessary or Medical Necessity	OneCare: Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. OneCare Connect: Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	A beneficiary enrolled in a CalOptima program.
Non-Exception	A Non-Exception is a type of coverage determination. A Non-Exception is a request for coverage for a drug that is included on CalOptima's Formulary subject to a Utilization Management restriction (e.g. Step Therapy, Prior Authorization, Quantity Limit), and the requestor is attempting to satisfy the requirements for coverage.
Participating Pharmacy	Any Pharmacy that is credentialed by, and contracted with, the Pharmacy Benefit Manager (PBM) to provide Pharmaceutical Services to Members.
Pharmacy Benefits Manager (PBM)	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and Prior Authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.
Prescriber	A healthcare professional who is authorized under State law or other applicable law to write prescriptions.
Prescriber Supporting Statement	A statement of medical justification consistent with the requirements set forth in Title 42 of the Code of Federal Regulations, Section 423.578(b)(5).

For 20201001 BOD Review Only

Term	Definition
	An oral or written supporting statement, provided by the Prescriber, that the requested prescription drug is Medically Necessary to treat the Member's disease or medical condition because— (i) All of the Covered Part D Drugs on any tier of the Formulary for treatment for the same condition would not be as effective for the Member as the non-Formulary drug, would have adverse effects for the Member, or both; (ii) The prescription drug alternative(s) listed on the Formulary or required to be used in accordance with Step Therapy requirements— (A) Has been ineffective in the treatment of the Member's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence and the known relevant physical or mental characteristics of the Member and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or (B) Has caused or based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the Member; or (iii) The number of doses that is available under a dose restriction for the prescription drug has been ineffective in the treatment of the Member's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence and the known relevant physical or mental characteristics of the Member and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
Prior Authorization (PA)	The Formulary restriction which requires approval from CalOptima before the requested medication is covered.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.
Quantity Limit (QL)	The Formulary restriction which limits the amount of the requested medication that CalOptima will cover.
Redetermination (RD) (Pharmacy)	The first level of the appeal process, which involves a Part D plan sponsor reevaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.
Step Therapy (ST)	The Formulary restriction which requires an enrollee to first try certain drugs to treat a medical condition before the requested medication is covered.
Tiering Exception	A Tiering Exception is a type of coverage determination. A Tiering Exception is a request to obtain a non-preferred drug in a higher cost-sharing tier at the lower cost-sharing terms applicable to drugs in a lower cost-sharing tier.
Tolling	Extending the timeframe for review of a standard or expedited Formulary or Tiering Exception for a Covered Part D Drug when a Prescriber Supporting Statement has not been received.
Utilization Management (UM)	Requirements or limits on coverage. Utilization Management may include, but is not limited to, Prior Authorization, Quantity Limit, or Step Therapy restrictions.

1

For 20201001 BOD Review Only

Enrollee's Name:_____(Optional)

Drug and Prescription Number:_____(Optional)

Medicare Prescription Drug Coverage and Your Rights

Your Medicare rights

You **have the right to request a coverage determination** from your Medicare drug plan if you disagree with information provided by the pharmacy. You also **have the right to request a special type of coverage determination called an "exception"** if you believe:

- you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;"
- a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- you need to take a non-preferred drug and you want the plan to cover the drug at a preferred drug price.

What you need to do

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan's toll-free phone number on the back of your plan membership card, or by going to your plan's website. You or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare drug plan:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you with a written decision. If coverage is not approved, the plan's notice will explain why coverage was denied and how to request an appeal if you disagree with the plan's decision.

Refer to your plan materials or call 1-800-Medicare for more information.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-0975. The time required to complete this information collection is estimated to average 1 minute per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.

OMB Approval No. 0938-0975

Enrollee's Name: _____ (Optional)

Drug and Prescription Number: _____ (Optional)

Medicare Prescription Drug Coverage and Your Rights

Your Medicare rights

You **have the right to request a coverage determination** from your Medicare drug plan if you disagree with information provided by the pharmacy. You also **have the right to request a special type of coverage determination called an "exception"** if you believe:

- you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;"
- a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- you need to take a non-preferred drug and you want the plan to cover the drug at the preferred drug price.

What you need to do

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan's toll-free phone number on the back of your plan membership card, or by going to your plan's website. You or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare drug plan:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you with a written decision. If coverage is not approved, the plan's notice will explain why coverage was denied and how to request an appeal if you disagree with the plan's decision.

Refer to your plan materials or call 1-800-Medicare for more information.

[cover page for window envelope]

FIRST NAME AND LAST NAME
ADDRESS1
ADDRESS2
CITY STATE ZIP

Notice of Case Status

Today's Date

MEMBER FIRST AND LAST NAME
ADDRESS
CITY STATE ZIP

Member ID Number: CIN
Case Number: Case ID #

Dear MEMBER FIRST AND LAST NAME,

This letter is to inform you that your request for a [“standard initial decision for benefits”] [“standard initial decision for reimbursement”] [“fast initial decision”] [“standard” appeal] [“fast” appeal] was forwarded to an independent organization for review on <insert date>.

[For a “standard initial decision” request [for benefits] [for reimbursement]: Your case file was forwarded to an independent review organization because we did not provide you with an answer within [72 hours] [14 days] after receiving your [request][doctor’s supporting statement].***]***

[For a “fast initial decision” request: Your case file was forwarded to an independent review organization because we did not provide you with an answer within 24 hours after receiving your [request][doctor’s supporting statement].***]***

[For a “standard” appeal: Your case file was forwarded to an independent review organization because we did not provide you with an answer within 7 calendar days after receiving your appeal.***]***

[For a “fast” appeal: Your case file was forwarded to an independent review organization because we did not provide you with an answer within 72 hours after receiving your appeal.***]***

The law requires us to forward your case file to an independent review organization within 24 hours if we do not provide you with an answer within the required time frame.

The independent review organization has a contract with the Centers for Medicare & Medicaid services (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization. There is no charge for the copy.

You have the right to submit additional evidence about your case. If you choose to submit additional evidence, you should send it promptly to the independent review organization at:

MAXIMUS Federal Services
Medicare Part D QIC
3750 Monroe Ave., Suite #703
Pittsford, NY 14534-1302
Toll Free Fax: 1-866-825-9507
Customer Service: 1-877-456-5302

If you have any questions, or if you would like to request a copy of your case file, please contact OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929.

Thank you.

OneCare Connect Pharmacy Management

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. Limitations, copays, and restrictions may apply. For more information, call OneCare Connect Customer Service or read the OneCare Connect Member Handbook. Benefits and/or copayments may change on January 1 of each year. Please call our Customer Service number at 1-855-705-8823, 24 hours a day, 7 days a week. TDD/TTY users can call 1-800-735-2929.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

Chinese: □ **1-855-705-8823** (TTY: **1-800-735-2929**)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

Korean: □ □ : □ □ □ □ □ □ □ □ □ □ □ □ , □ . **1-855-705-8823** (TTY: **1-800-735-2929**)□ □ □ □ □ □ □ □ □ □ .

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-705-8823** (телетайп: **1-800-735-2929**).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:
ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم **1-855-705-8823** (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**)

Punjabi: Ä nS o Ämz: c ÑÇ□ps r År ÜmÑ Ük □s z ~Äyà { | ~T k ~{ Ñ~k Ç~h ÑU t Çk Vp wr n | Ø**1-855-705-8823** (TTY: **1-800-735-2929**) 'k Ñ w \ vØ

Cambodian: ę □ ¹ ĘĂŠlĐ¯ Ž lă Ă ąŁę Ł¹ đŁą ęč ă lő ĘĂ člđę l″ ĂŠ² Ę¾ţ ĎŁě ŁĹĺ Łţ č Ł lă ĐĘě ąŁĐă ę □ –Ž F] →ĄŁĂ¹ ĘĂ **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

Hindi: ˙ ∑ρ± ØfI ∑Ŵz ≤¥ύπ≠ŒHǂúz ≤ûЄ□π Ñ∂ſ˚≠ ∂ Jlu ρ◊qæøρ∑≠ρæ€ρÑÏ}≤π˛∞ øĮH**1-855-705-8823** (TTY: **1-800-735-2929**) ≤∏û ün û ∏JI

Thai: ‡ŴÑ : ∑ç•¥øĢ¡ ‘À%∏Ĵ•¥Ã¬ƒ∑„ç ƒæ“ƒ å∨ţÕŸ¶®‘À%ıçƒ◊„∏ƒ**1-855-705-8823** (TTY: **1-800-735-2929**).

[cover page for window envelope]

FIRST NAME AND LAST NAME
ADDRESS1
ADDRESS2
CITY STATE ZIP

Notice of Case Status

Today's Date

<MEMBER FIRST AND LAST NAME>
<ADDRESS>
<CITY STATE ZIP>

Member ID Number: <CIN>
Case Number: <Case ID #>

Dear <MEMBER FIRST AND LAST NAME>,

This letter is to inform you that your request for a [“standard initial decision for benefits”] [“standard initial decision for reimbursement”] [“fast initial decision”] [“standard” appeal] [“fast” appeal] was forwarded to an independent organization for review on <insert date>.

[For a “standard initial decision” request [for benefits] [for reimbursement]: Your case file was forwarded to an independent review organization because we did not provide you with an answer within [72 hours] [14 days] after receiving your [request][doctor’s supporting statement].***]***

[For a “fast initial decision” request: Your case file was forwarded to an independent review organization because we did not provide you with an answer within 24 hours after receiving your [request][doctor’s supporting statement].***]***

[For a “standard” appeal: Your case file was forwarded to an independent review organization because we did not provide you with an answer within 7 calendar days after receiving your appeal.***]***

[For a “fast” appeal: Your case file was forwarded to an independent review organization because we did not provide you with an answer within 72 hours after receiving your appeal.***]***

The law requires us to forward your case file to an independent review organization within 24 hours if we do not provide you with an answer within the required time frame.

The independent review organization has a contract with the Centers for Medicare & Medicaid services (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization. There is no charge for the copy.

You have the right to submit additional evidence about your case. If you choose to submit additional evidence, you should send it promptly to the independent review organization at:

MAXIMUS Federal Services
Medicare Part D QIC
3750 Monroe Ave., Suite #703
Pittsford, NY 14534-1302
Toll Free Fax: 1-866-825-9507
Customer Service: 1-877-456-5302

If you have any questions, or if you would like to request a copy of your case file, please contact OneCare (HMO SNP) Customer Service at 1-877-412-2734, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929.

Thank you.

OneCare Pharmacy Management

OneCare (HMO SNP) is a Medicare Advantage organization with a Medicare Contract and a contract with the California Medi-Cal (Medicaid) program. Enrollment in OneCare depends on contract renewal. OneCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-877-412-2734**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-877-412-2734** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-412-2734** (TTY: **1-800-735-2929**).

Chinese: □ **1-877-412-2734** (TTY: **1-800-735-2929**)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-412-2734** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-412-2734** (TTY: **1-800-735-2929**).

Korean: □ □ : □ □ □ □ □ □ □ □ □ □ □ , □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ . **1-877-412-2734** (TTY: **1-800-735-2929**)□ □ □ □ □ □ □ □ □ □ .

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-877-412-2734** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-877-412-2734** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-412-2734** (телетайп: **1-800-735-2929**).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-877-412-2734** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:
ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**) **1-877-412-2734**

Punjabi: Ä¬n S o Ä¬mZ: c Ñk Ç□ p§ ~r År ẅmÑ Ük □s ~z ~Ä¬y□a {| ~T k ~{ ÑN~k Ç~h ÑwU t Ç k Vp wr n | Ø**1-877-412-2734** (TTY: **1-800-735-2929**) 'k Ñ ~w \ v Ø

Cambodian: ę □ ¹ ĘĂŠ lĐ¯ Ž lă Ă ąIłę Ł, ¹ đĿ ąœę č ăIő ĘĂ, č Iđ ę l″ ĂŠ° Ę¾t, ĎIě Ł ĹÍ Iţ č Ł lă œĘě ą Ł Đă ę □ –Ž ₣] →ĄIĂ ¹ ĘĂ **1-877-412-2734**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-877-412-2734** (TTY: **1-800-735-2929**).

Hindi: ˙ ∑ρ± ØΠ∑Ŵz ≤¥ύπ≠ΘΗ≠ύz ≤ûЄ□πÑ∂ſ≠ ∂ Jμ ρ Ωραæøρ∑≠ραæЄρÑÏ}≤π ¸ ∞ øΗ**1-877-412-2734** (TTY: **1-800-735-2929**) ≤∏û üπ û ∏Π

Thai: ¡ƒ : ∑Ò¥øĢ ¡ ‘À%∏ƒ¶¥Ã¬ƒ∑ ¸ƒ℮‘ƒ å√ÕŸ∏®‘À%℮ƒ∑∏ƒ**1-877-412-2734** (TTY: **1-800-735-2929**).

Form Approved
OMB No. 0938-0950

APPOINTMENT OF REPRESENTATIVE

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier Number (provider as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____ , hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (DHHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of DHHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Charging of Fees for Representing Beneficiaries before the Secretary of DHHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of DHHS (i.e., an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council review, or a proceeding before an ALJ or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before DHHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance if you are filing a grievance, initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227). TTY users please call 1-877-486-2048.

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: **AltFormatRequest@cms.hhs.gov**.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 417, 422, and 423

[CMS–4190–F]

RIN 0938–AT97

Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This final rule will revise regulations for the Medicare Advantage (MA or Part C) program, Medicare Prescription Drug Benefit (Part D) program, and Medicare Cost Plan program to implement certain sections of the Bipartisan Budget Act of 2018 and the 21st Century Cures Act. In addition, it will enhance the Part C and D programs, codify several existing CMS policies, and implement other technical changes.

DATES: *Effective Date:* These regulations are effective August 3, 2020.

Applicability Dates: Except for §§ 422.166(a)(2)(i), 423.186(a)(2)(i), and 422.514(d)(1) and (2), the provisions in this rule are applicable beginning January 1, 2021. The changes to §§ 422.166(a)(2)(i) and 423.186(a)(2)(i) are applicable beginning January 1, 2022. The provisions of § 422.514(d)(1), are applicable beginning January 1, 2022. The provisions of § 422.514(d)(2) are applicable beginning January 1, 2023.

FOR FURTHER INFORMATION CONTACT: Theresa Wachter, (410) 786–1157, or Cali Diehl, (410) 786–4053—General Questions.

Kimberlee Levin, (410) 786–2549—Part C Issues.

Lucia Patrone, (410) 786–8621—Part D Issues.

Kristy Nishimoto, (206) 615–2367—Beneficiary Enrollment and Appeals Issues.

Stacy Davis, (410) 786–7813—Part C and D Payment Issues.

Melissa Seeley, (212) 616–2329—D–SNP Issues.

SUPPLEMENTARY INFORMATION: CMS intends to address all of the remaining proposals from the February 2020 proposed rule in subsequent rulemaking. Therefore, CMS plans to make any provisions adopted in the subsequent, second final rule, although effective on or before January 1, 2021, applicable no earlier than January 1, 2022. Notwithstanding the foregoing, for proposals from the February 2020 proposed rule that would codify statutory requirements that are already in effect, CMS reminds readers and plan sponsors that the statutory provisions apply and will continue to be enforced. Similarly, for the proposals from the February 2020 proposed rule that would implement the statutory requirements in sections 2007 and 2008 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (hereinafter referred to as the SUPPORT Act), CMS intends to implement these statutes consistent with their effective provisions.

I. Executive Summary and Background

A. Executive Summary

1. Purpose

The primary purpose of this final rule is to implement certain sections of the following federal laws related to the Medicare Advantage (MA or Part C) and Prescription Drug Benefit (Part D) programs before the contract year 2021 MA plan bids (due by statute on the first Monday in June):

- The Bipartisan Budget Act of 2018 (hereinafter referred to as the BBA of 2018)
- The 21st Century Cures Act (hereinafter referred to as the Cures Act)

The rule also includes a number of changes to strengthen and improve the Part C and D programs, codifies in regulation several CMS interpretive policies previously adopted through the annual Call Letter and other guidance documents, and implements other technical changes. We took a measured approach to review each provision proposed and focused finalizing in this first final rule those most helpful for bidding, those that address the Coronavirus Disease (COVID–19) pandemic and public health emergency, as well as those topics on which issuing a final rule now would advance the MA program.

While we intend to address the remaining proposals from the February 18, 2020, proposed rule (85 FR 9002) not included in this final rule in subsequent rulemaking, we are focusing in this final rule on more immediate regulatory actions. CMS plans to make any provisions adopted in the subsequent, second final rule, although effective on or before January 1, 2021, applicable no earlier than January 1, 2022. Notwithstanding the foregoing, for proposals from the February 2020 proposed rule that would codify statutory requirements that are already in effect,[1] CMS reminds readers and plan sponsors that the statutory provisions apply and will continue to be enforced. Similarly, for the proposals from the February 2020 proposed rule that would implement the statutory requirements in sections 2007 and 2008 of the SUPPORT Act, CMS intends to implement the statute consistent with its effective provisions.

2. Summary of the Major Provisions

a. Medicare Advantage (MA) Plan Options for End-Stage Renal Disease (ESRD) Beneficiaries (§§ 422.50, 422.52, and 422.110)

The Cures Act (Pub. L. 114–255) amended sections 1851, 1852, and 1853 of the Act to expand enrollment options for individuals with end stage renal disease (ESRD) and make associated payment and coverage changes to the MA and original Medicare programs. Specifically, since the beginning of the MA program, individuals with ESRD have not been able to enroll in MA plans subject to limited exceptions. Section 17006(a) of the Cures Act removed this prohibition effective for plan years beginning on or after January 1, 2021. We are codifying this change with revisions to §§ 422.50(a)(2), 422.52, and 422.110.

b. Medicare Fee-for-Service (FFS) Coverage of Costs for Kidney Acquisitions for Medicare Advantage (MA) Beneficiaries (§ 422.322)

With this new enrollment option, the Cures Act also made several payment changes in the MA and original Medicare FFS programs. Section 17006(c) of the Cures Act amended section 1852(a)(1)(B)(i) of the Act to exclude coverage for organ acquisitions for kidney transplants from the Medicare benefits an MA plan is required to cover for an MA enrollee, including as covered under section 1881(d) of the Act. Effective January 1, 2021, these costs will be covered under the original Medicare FFS program. Section 17006(c)(2) of the Cures Act also amended section 1851(i) of the Act, providing that CMS may pay an entity other than the MA organization that offers the plan in which the individual is enrolled for expenses for organ

[1] These include the following BBA of 2018 provisions: Improvements to Care Management Requirements for Special Needs Plans (SNPs); Coverage Gap Discount Program Updates; and Part D Income Related Monthly Adjustment Amount (IRMAA) Calculation Update for Part D Premium Amounts.

acquisitions for kidney transplants described in section 1852(a)(1)(B)(i) of the Act. We are finalizing changes to our regulation at § 422.322 in accordance with these new statutory requirements.

c. Exclusion of Kidney Acquisition Costs From Medicare Advantage (MA) Benchmarks (§§ 422.258 and 422.306)

Consistent with how the original Medicare FFS program will cover costs of organ acquisitions for kidney transplants for individuals in an MA plan, section 17006(b) of the Cures Act also amended section 1853 of the Act to exclude these costs from the MA benchmarks used in determining payment to MA plans. Specifically, the Secretary, effective January 1, 2021, is required to exclude the estimate of standardized costs for payments for organ acquisitions for kidney transplants from MA benchmarks and capitation rates. We are finalizing changes to our regulations at §§ 422.258(d) and 422.306 in accordance with these new statutory requirements.

d. Medicare Advantage (MA) and Part D Prescription Drug Program Quality Rating System (§§ 422.162, 422.166, 423.182, and 423.186)

In the Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program Final Rule (CMS–4182–F) (hereinafter referred to as the April 2018 final rule), we codified the methodology for the Star Ratings system for the MA and Part D programs, respectively, at §§ 422.160 through 422.166 and §§ 423.180 through 423.186. We have stated we will propose through rulemaking any changes to the methodology for calculating the ratings, the addition of new measures, and substantive measure changes.

At this time, we are finalizing the increased weight of patient experience/complaints and access measures from 2 to 4. We are also finalizing our proposal to directly remove outliers prior to calculating the cut points to further increase the predictability and stability of the Star Ratings system, but we are delaying the application of outlier deletion until the 2022 measurement year which coincides with the 2024 Star Ratings produced in October 2023. We are also finalizing removal of the Rheumatoid Arthritis Management measure. Finally, we are finalizing the update to the Part D Statin Use in Persons with Diabetes measure weighting category. Unless otherwise stated, data will be collected and performance measured using these rules and regulations for the 2021 measurement period and the 2023 Star Ratings. The remaining Star Ratings provisions of the proposed rule will be addressed later and, therefore, are not being finalized in this rule. Those provisions include codifying additional existing rules for calculating MA Quality Bonus Payments ratings, implementing updates to the Health Outcomes Survey measures, adding new Part C measures, clarifying the rules around consolidations when data are missing due to data integrity concerns, modifying the extreme and uncontrollable circumstance policy for multiple year-affected contracts and to clarify rules when data are missing due to data integrity concerns, and additional technical clarifications.

e. Medical Loss Ratio (MLR) (§§ 422.2420, 422.2440, and 423.2440)

We are finalizing our proposal to amend the MA medical loss ratio (MLR) regulation at § 422.2420 so that the incurred claims portion of the MLR numerator includes all amounts that an MA organization pays (including under capitation contracts) for covered services. Currently, incurred claims in the MLR numerator include direct claims paid to providers (including under capitation contracts with physicians) for covered services furnished to all enrollees under an MA contract. This amendment will also include in the incurred claims portion of the MLR numerator amounts paid for covered services to individuals or entities that do not meet the definition of ''provider'' as defined at § 422.2.

We are finalizing our proposal to codify in our regulations at §§ 422.2440 and 423.2440 the definitions of partial, full, and non-credibility and the credibility factors that CMS published in the May 2013 Medicare Program; Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs Final Rule (78 FR 31284) (hereinafter referred to as the May 2013 Medicare MLR final rule). It is more consistent with the policy and principles articulated in Executive Order 13892 on Promoting the Rule of Law Through Transparency and Fairness in Civil Administrative Enforcement and Adjudication (October 9, 2019) that we codify these definitions and factors in the applicable regulations.

Additionally, we are finalizing our proposal to amend § 422.2440 to provide for the application of a deductible factor to the MLR calculation for MA medical savings account (MSA) contracts that receive a credibility adjustment. The deductible factor serves as a multiplier on the applicable credibility adjustment. This additional adjustment for MA MSAs is appropriate because the variability of claims experience is greater under health insurance policies with higher deductibles than under policies with lower deductibles, with high cost or outlier claims representing a larger portion of the overall claims experience of plans with high deductibles. This is the case because high-deductible health plan enrollees' medical expenses must exceed a higher threshold before the plan begins to incur claims costs that can be included in the MLR numerator. The deductible factor reduces the risk that an MSA contract will fail to meet the MLR requirement as a result of random variations in claims experience. We are finalizing our proposal to adopt the same deductible factors that apply under the commercial MLR regulations at 45 CFR part 158.

f. Medicare Advantage (MA) and Cost Plan Network Adequacy (§§ 417.416 and 422.116)

We are strengthening network adequacy rules for MA plans by codifying our existing network adequacy methodology and finalizing policies that address maximum time and distance standards in rural areas, telehealth, and Certificate of Need (CON) laws. The authorization of additional telehealth benefits pursuant to the BBA of 2018 incentivizes new ways for MA plans to cover beneficiary access to health care beginning in 2020. As a result, CMS has been examining its network adequacy standards overall to determine how contracted telehealth providers should be considered when evaluating the adequacy of an MA plan network. In order to expand access to MA plans where network development can be challenging, we are reducing the percentage of beneficiaries that must reside within the maximum time and distance standards in non-urban counties (Micro, Rural, and Counties with Extreme Access Considerations (CEAC) county type designations) from 90 percent to 85 percent in order for an MA plan to comply with network adequacy standards. Also, MA plans will be eligible to receive a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards when they contract with telehealth providers in the following provider specialty types: Dermatology, Psychiatry, Cardiology, Otolaryngology, Neurology, Ophthalmology, Allergy and Immunology, Nephrology, Primary Care,

Gynecology/OB/GYN, Endocrinology, and Infectious Diseases. Additionally, MA organizations may also receive a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards for affected provider and facility types in states that have CON laws, or other state imposed anti-competitive restrictions, that limit the number of providers or facilities in a county or state. We solicited comments from stakeholders on various aspects of our proposal, which informed the network adequacy methodology adopted in this final rule.

g. Special Election Periods (SEPs) for Exceptional Conditions (§§ 422.62, 422.68, 423.38, and 423.40)

Sections 1851(e)(4) and 1860D–1(b)(3) of the Act establish special election periods (SEPs) during which, if certain circumstances exist, an individual may request enrollment in, or disenrollment from, MA and Part D plans. The Secretary also has the authority to create SEPs for individuals who meet other exceptional conditions. We are codifying a number of SEPs that we have adopted and implemented through subregulatory guidance as exceptional circumstances SEPs. Codifying our current policy for these SEPs provides transparency and stability to the MA and Part D programs by ensuring that these SEPs are known and changed only through additional rulemaking. Among the finalized SEPs are the SEP for Government Entity-Declared Disaster or Other Emergency, the SEP for Employer/Union Group Health Plan (EGHP) elections, and the SEP for Individuals Who Disenroll in Connection with a CMS Sanction. We are also establishing two additional SEPs for exceptional circumstances: The SEP for Individuals Enrolled in a Plan Placed in Receivership and the SEP for Individuals Enrolled in a Plan that has been identified by CMS as a Consistent Poor Performer.

3. Summary of Costs and Benefits

Provision	Description	Impact
Medicare Advantage (MA) Plan Options for End-Stage Renal Disease (ESRD) Beneficiaries (§§ 422.50, 422.52, and 422.110).	CMS is codifying requirements under section 17006 of the Cures Act. Effective for the plan year beginning January 1, 2021, CMS is removing the prohibition on beneficiaries with ESRD enrolling in an MA plan.	To estimate the impact, we used a pre-statute baseline. The analysis shows that removing the prohibition for ESRD beneficiaries to enroll in MA plans results in net costs to the Medicare Trust Funds ranging from $23 million in 2021 to $440 million in 2030.
Medicare Fee-for-Service (FFS) Coverage of Costs for Kidney Acquisitions for Medicare Advantage (MA) Beneficiaries (§ 422.322).	CMS is codifying requirements under section 17006 of the Cures Act. Effective for the plan year beginning January 1, 2021, CMS is finalizing that MA organizations will no longer be responsible for costs for organ acquisitions for kidney transplants for their beneficiaries. Instead, Medicare FFS will cover the kidney acquisition costs for MA beneficiaries, effective 2021.	To estimate the impact, we used a pre-statute baseline. This analysis shows that FFS coverage of kidney acquisition costs for MA beneficiaries results in net costs to the Medicare Trust Funds ranging from $212 million in 2021 to $981 million in 2030.
Exclusion of Kidney Acquisition Costs from Medicare Advantage (MA) Benchmarks (§§ 422.258 and 422.306).	CMS is codifying requirements under section 17006 of the Cures Act. Effective for the plan year beginning January 1, 2021, CMS is removing costs for organ acquisitions for kidney transplants from the calculation of MA benchmarks and annual capitation rates.	To estimate the impact, we used a pre-statute baseline. This analysis shows that excluding kidney acquisition costs from MA benchmarks results in net savings estimated to range from $594 million in 2021 to $1,346 million in 2030.
Medicare Advantage (MA) and Part D Prescription Drug Program Quality Rating System (§§ 422.162, 422.166, 423.182, and 423.186).	CMS is finalizing an increase in the weight of patient experience/complaints and access measures. CMS is also finalizing the use of Tukey outlier deletion, which is a standard statistical methodology for removing outliers, to increase the stability and predictability of the star measure cut points. However, the application of Tukey outlier deletion will be delayed until the 2024 Star Ratings.	Updating the patient experience/complaints and access measures weight creates a cost which is offset after the first year by using the Tukey outlier deletion. The net cost to the Medicare Trust Fund from the increased weight is $345.1 million in 2024; the net savings from both the increased weight and Tukey outlier deletion will grow over time reaching $999.4 million by 2030. The net reduction in spending to the Medicare Trust Fund through and including 2030 is $4.1 billion.

Back to Agenda Back to Item

Provision	Description	Impact
Medical Loss Ratio (MLR) (§§ 422.2420, 422.2440, and 423.2440).	CMS is finalizing our three proposed amendments to the Medicare MLR regulations. (1) We will allow MA organizations to include in the MLR numerator as ''incurred claims'' all amounts paid for covered services, including amounts paid to individuals or entities that do not meet the definition of ''provider'' at § 422.2. (2) We also are codifying our definitions of partial, full, and non-credibility and credibility factors that CMS published in the May 2013 Medicare MLR final rule (78 FR 31296) for MA and Part D MLRs. (3) We are finalizing our proposal to apply a deductible factor to the MLR calculation for MA MSA contracts receiving a credibility adjustment. The deductible factor, which functions as a multiplier on the credibility adjustment factor, is calibrated so that the probability that a contract will fail to meet the MLR requirement is the same for all contracts that receive a credibility adjustment, regardless of the deductible level.	(1) Our change to the type of expenditures that can be included in ''incurred claims'' will have neutral dollar impact on the Medicare Trust Fund. These provisions will result in a transfer of funds from the Treasury, through the Medicare Trust Fund, to MA organizations. This transfer will take the form of a reduction in the remittance amounts withheld from MA capitated payments. The amount of this transfer is $35 to $55 million a year, resulting in plans obtaining $455 million over 10 years. (2) Codifying the definitions of partial, full, and non-credibility and the credibility factors is unlikely to have any impact on the Medicare Trust Fund. (3) The deductible factor to the MLR calculation for MA MSA contracts is estimated to result in a gradually increasing cost to the Medicare Trust Fund of $1 to $6 million per year, arising from the Trust Fund paying for benefits due to expected increased enrollment, and will result in a $40 million cost through, and including, 2030.
Medicare Advantage (MA) and Cost Plan Network Adequacy (§§ 417.416 and 422.116).	CMS is—(1) strengthening network adequacy rules for MA and cost plans and to make them more transparent to plans by codifying our existing network adequacy methodology and standards, with some modifications; (2) allowing MA plans to receive a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards when they contract with certain telehealth providers; (3) allowing MA organizations to receive a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards for affected provider and facility types in states that have CON laws, or other state imposed anti-competitive restrictions, that limit the number of providers or facilities in a county or state where CMS has not already customized the standards for that area; and (4) reducing the required percentage of beneficiaries residing within maximum time and distance standards in certain county types (Micro, Rural, and CEAC).	Changes to network standards are unlikely to have any impact on the Medicare Trust Fund.
Special Election Periods (SEPs) for Exceptional Conditions (§§ 422.62, 422.68, 423.38, and 423.40).	CMS is codifying a number of SEPs adopted and implemented through subregulatory guidance as exceptional circumstances SEPs. CMS is also establishing two new SEPs for exceptional circumstances: The SEP for Individuals Enrolled in a Plan Placed in Receivership and the SEP for Individuals Enrolled in a Plan that has been identified by CMS as a Consistent Poor Performer.	This provision codifies existing practice since MA organizations and Part D plan sponsors are currently assessing applicants' eligibility for election periods as part of existing enrollment processes. Consequently, the provision will not have added impact.

B. Background

We received approximately 490 timely pieces of correspondence containing multiple comments on the provisions implemented within this final rule from the proposed rule titled ''Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly'' which published February 18, 2020, in the **Federal Register** (85 FR 9002). Comments were submitted by MA health plans, Part D sponsors, MA and beneficiary advocacy groups, trade associations, providers, pharmacies and drug companies, states, telehealth and health technology organizations, policy research organizations, actuarial and law firms, MACPAC, MedPAC, and other vendor and professional associations.

The proposals we are finalizing in this final rule range from minor clarifications to more significant modifications based the comments received. As noted previously, we intend to address the proposals from the February 2020 proposed rule that are not included in this final rule in subsequent rulemaking. Summaries of the public comments received and our responses to those public comments are set forth in the various sections of this final rule under the appropriate headings. We also note that some of the public comments received for the provisions implemented in this final rule were outside of the scope of the proposed rule. For example, we received comments about how much MA organizations pay network providers, and comments that recommend CMS adopt completely new Star Ratings measures or change HEDIS

measures during the COVID–19 pandemic. CMS did not make any proposals in the February 2020 proposed rule on these topics, and as such, those out-of-scope public comments are not addressed in this final rule. However, we note that in this final rule we are not addressing comments received with respect to the other provisions of the February 2020 proposed rule that we are not finalizing at this time. Rather, we will address these comments in subsequent rulemaking, as appropriate.

II. Implementation of Certain Provisions of the Bipartisan Budget Act of 2018

A. Special Supplemental Benefits for the Chronically Ill (SSBCI) (§ 422.102)

The BBA of 2018 (Pub. L. 115–123) was signed into law on February 9, 2018. The law included new authorities concerning supplemental benefits that may be offered to chronically ill enrollees in Medicare Advantage (MA) plans, specifically amending section 1852(a)(3) of the Act to add a new subparagraph (D) authorizing a new category of supplemental benefits that may be offered by MA plans. We discussed this new authority in the April 2018 final rule (83 FR 16481 through 16483).[2] We proposed to codify the existing guidance (April 2019 Health Plan Management System (HPMS) Memo [3] and the 2020 Call Letter [4]) and parameters for these special supplemental benefits for chronically ill enrollees at § 422.102(f) to implement section 1852(a)(3)(D) of the Act.

Specifically, the BBA of 2018 amended section 1852(a)(3) of the Act to: (1) Authorize MA plans to provide additional supplemental benefits that have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee to chronically ill enrollees; (2) permit those additional supplemental benefits to be not primarily health related; (3) define ''chronically ill enrollee'' to limit eligibility for these additional supplemental benefits; and (4) authorize CMS to waive uniformity requirements in connection with providing these benefits to eligible chronically ill enrollees. We refer to these benefits hereafter as Special Supplemental Benefits for the Chronically Ill (SSBCI). The heading for new subparagraph (D) of section 1852(a)(3) of the Act, as added by the BBA, states, ''Expanding supplemental benefits to meet the needs of chronically ill enrollees.'' Consistent with this text, we interpret the intent of this new category of supplemental benefits as enabling MA plans to better tailor benefit offerings, address gaps in care, and improve health outcomes for the chronically ill enrollee population.

Section 1852(a)(3)(D)(ii) of the Act, as amended, defines a chronically ill enrollee as an individual who—

- Has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;
- Has a high risk of hospitalization or other adverse health outcomes; and
- Requires intensive care coordination.

Thus, with respect to SSBCI benefits, at § 422.102(f)(1)(i), we proposed to codify this definition of a chronically ill enrollee. Section 1859(f)(9) of the Act requires us to convene a panel of clinical advisors to establish and update a list of conditions that meet the definition of a severe or disabling chronic condition under section 1859(b)(6)(B)(iii) of the Act, which provides how having such a condition is an eligibility criterion for enrollment in a chronic care special needs plan. The standard for severe or disabling chronic condition under section 1859(b)(6)(B)(iii) of the Act is substantially similar to the criterion used in defining ''chronically ill enrollee'' for purposes of SSBCI eligibility. We proposed that MA plans may consider any enrollee with a condition identified on this list to meet the statutory criterion of having one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee. Further, an MA plan may consider any chronic condition not identified on this list if that condition is life threatening or significantly limits the overall health or function of the enrollee. We explained that our proposal was based on our policy goal of allowing MA plans the flexibility to continue to innovate around providing care for their specific plan populations. This includes targeted chronic conditions. We stated that we recognize that there may be some conditions or a subset of conditions in a plan population that may meet the statutory definition of a chronic condition (for purposes of the statutory definition of a chronically ill enrollee), but may not be present on the list. To encourage plans to identify needs within their unique plan population and to avoid preventing a plan from addressing a condition or need in their population that may not be on the list, we proposed regulation text permitting us to publish a non-exhaustive list of medically complex chronic conditions as determined by the panel as described in section 1859(b)(6)(B)(iii) to be life threatening or significantly limit the overall health or function of an individual. This was proposed at § 422.102(f)(1)(i)(B).

As we explained in the proposed rule, we did not propose that MA plans be required to submit to CMS the processes used to identify chronically ill enrollees that meet the three pronged definition of chronically ill enrollee.

However, plans should describe the chronic conditions for which they will offer SSBCI in the notes field in the plan benefit package submitted to CMS. We emphasized that all three criteria must be met for an enrollee to be eligible for the SSBCI authorized under section 1852(a)(3)(D) of the Act. In subregulatory guidance (April 2019 HPMS Memo and the 2020 Call Letter), CMS noted that we expect MA plans to document their determinations about an enrollee's eligibility for SSBCI based on the statutory definition. We proposed to codify this as a requirement at § 422.102(f)(3)(ii). In addition, we also proposed at § 422.102(f)(3)(ii) to require plans to make information and documentation (for example, copies of the internal policies used to make the determinations, etc.) related to determining enrollee eligibility as a chronically ill enrollee available to CMS upon request.

We proposed a definition of SSBCI at paragraph (f)(1)(ii). In addition to limiting the class of enrollees who may be eligible to receive the new SSBCI benefits to the chronically ill, section 1852(a)(3)(D) of the Act requires that the specific supplemental benefit provided under this authority have a reasonable expectation of improving or maintaining the health or overall function of the enrollee. We proposed to codify this statutory requirement as part of the definition of SSBCI. Because SSBCI are supplemental benefits, they must also comply with the criteria for supplemental benefits that we proposed to codify at § 422.100(c)(2)(ii), which was discussed in detail in section VI.F. of the proposed rule. We are not addressing that proposal in this final rule and intend to address it in a future final rule. We considered whether the regulation for SSBCI should explicitly reference those requirements for supplemental benefits (proposed in § 422.100(c)(2)(ii)) to make this clear

[2] *https://www.govinfo.gov/content/pkg/FR-2018-04-16/pdf/2018-07179.pdf.*

[3] *https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf.*

[4] *https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf.*

and solicited comment on this point. Traditionally, CMS has required supplemental benefits to be benefits that: (1) Are primarily health related; (2) require the MA plan to incur a non-zero medical cost; and (3) are not covered under Medicare Parts A, B or D. In light of the authority in section 1852(a)(3)(D) of the Act for SSBCI, we modified some aspects of this longstanding policy to address SSBCI. First, as the statute provides that SSBCI may be not primarily health related, we proposed specific text on this point in both §§ 422.100(c)(2)(ii) and 422.102(f)(1)(ii). Second, we proposed regulation text at § 422.100(c)(2)(ii)(B) that the requirement that the MA organization incur a non-zero direct medical cost for all supplemental benefits would mean, in the context of SSBCI that are not primarily health related, the MA organization must incur a non-zero direct non-administrative cost for the SSBCI. In all other respects not specifically addressed as part of our proposal, SSBCI would be treated like and subject to the same standards as other supplemental benefits. Although we are not finalizing the requirements for supplemental benefits proposed to be codified at § 422.100(c)(2) in this final rule, we are clarifying that our final rule for SSBCI at § 422.102(f) incorporates these concepts.

Under section 1852(a)(3)(D)(ii)(I) of the Act, SSBCI benefits may include items or services that are not primarily health related. As discussed in detail in section VI.F. of the proposed rule, a primarily health related benefit is an item or service that is used to diagnose, compensate for physical impairments, acts to ameliorate the functional/psychological impact of injuries or health conditions, or reduces avoidable emergency and healthcare utilization. Therefore, at § 422.102(f)(1)(ii), we proposed to codify, as part of the definition, that SSBCI benefits may be non-primarily health related SSBCI benefits. Our proposed regulation text included a cross-reference to the regulation text we proposed at § 422.100(c)(2)(ii) to codify the definition of primarily health related. In the proposed rule, we made clear that in all cases, an SSBCI must have, with respect to a chronically ill enrollee, a reasonable expectation of improving or maintaining the health or overall function of the enrollee. By including it in the definition, we proposed to implement the statutory authority for MA plans to offer both primarily health and non-primarily health related SSBCI. We summarized in the proposed rule how the 2019 HPMS memo provided examples of what could be non-primarily health related SSBCI benefits, depending on the needs and health or overall function of the chronically ill enrollee. Those examples included: Meals (beyond a limited basis), food and produce, transportation for non-medical needs, pest control, indoor air quality and equipment and services, access to community or plan-sponsored programs and events to address enrollee social needs (such as non-fitness club memberships, community or social clubs, park passes, etc.), complementary therapies (offered alongside traditional medical treatment), services supporting self-direction, structural home modifications, and general supports for living (for example, plan-sponsored housing consultations and/or subsidies for rent or assisted living communities or subsidies for utilities such as gas, electric, and water). We stated in the proposed rule that the 2019 HPMS memo this guidance was equally applicable to our proposed regulation and part of how we intended our proposed regulation to be implemented and enforced.

We explained in the proposed rule another way that the statutory authority for SSBCI to be not primarily health related would be part of our proposed regulation. Unlike with traditional supplemental benefits, MA plans might not incur direct medical costs in furnishing or covering SSBCI. In the CY 2020 Call Letter, we issued guidance that so long as an MA plan incurs a non-zero non-administrative cost in connection with SSBCI, the benefits would be considered to meet this standard. As supplemental benefits, SSBCI may also take the same form as traditional supplemental benefits. For example, reductions in cost sharing for benefits under the original Medicare fee-for-service program are an allowable supplemental benefit, as reflected in the definitions of mandatory supplemental benefit in § 422.2. Thus, we stated in the proposed rule that SSBCI can be in the form of—

- Reduced cost sharing for Medicare covered benefits (such as to improve utilization of high-value services that meet the definition of SSBCI);
- Reduced cost sharing for primarily health related supplemental benefits;
- Additional primarily health related supplemental benefits; or
- Additional non-primarily health related supplemental benefits.

Eligibility for SSBCI must be determined based on identifying the enrollee as a chronically ill enrollee, using the statutory definition, and if the item or service has a reasonable expectation of improving or maintaining the health or overall function of the enrollee. In the April 2019 HPMS memo CMS clarified that MA plans can provide non-primarily health related supplemental benefits that address chronically ill enrollees' social determinants of health so long as the benefits maintain or improve the health or function of that chronically ill enrollee. MA plans may consider social determinants when determining eligibility for an SSBCI of health as a factor to help identify chronically ill enrollees whose health could be improved or maintained with SSBCI. However, MA plans may not use social determinants of health as the sole basis for determining eligibility for SSBCI. We proposed to codify (at § 422.102(f)(2)(iii)) the ability of an MA plan to consider social determinants (for example, food and housing insecurity) when determining whether an SSBCI benefit is likely to improve or maintain the health of a chronically ill enrollee,

We also explained how our proposal addressed the statutory authority to waive uniformity for an MA plan to offer SSBCI. Generally, § 422.100(d) and other regulations require all MA plan benefits to be offered uniformly to all enrollees residing in the service area of the plan. As explained in the April 2018 final rule (83 FR 16480 through 16485), MA plans may also provide access to services (or specific cost sharing or deductibles for specific benefits) that are tied to a disease state in a manner that ensures that similarly situated individuals are treated uniformly. Section 1852(a)(3)(D)(ii)(II) of the Act authorizes CMS to waive the uniformity requirements generally applicable to benefits covered by MA plans with respect to SSBCI, effective in CY 2020. As discussed in the April 2018 final rule (83 FR 16481 and 16482), this gives CMS the authority to allow MA plans to offer chronically ill enrollees supplemental benefits that are not uniform across the entire population of chronically ill enrollees in the MA plan and may vary SSBCI offered to the chronically ill as a specific SSBCI relates to the individual enrollee's specific medical condition and needs. We proposed to codify the authority for this waiver at § 422.102(f)(2)(ii) such that upon approval by CMS, an MA plan may offer non-uniform SSBCI.

In both the CY 2020 Call Letter and the April 2019 HPMS memo, we explained how we expect MA plans to: (i) Have written policies based on objective criteria (for example, health risk assessments, review of claims data, etc.) for determining SSBCI eligibility to receive a particular SSBCI benefit; (ii) document these criteria; and (iii) make

this information available to CMS upon request. We also proposed to codify requirements at § 422.102(f)(3)(iii) and (iv) for MA plans that offer SSBCI to have written policies based on objective criteria, document those criteria, to document each determination that an enrollee is eligible to receive an SSBCI, and to make this information available to CMS upon request. We explained in the proposed rule that objective criteria are necessary to address potential beneficiary appeals, complaints, and/or general oversight activities performed by CMS. We also proposed, at § 422.102(f)(3)(i), to require plans to have written policies for determining enrollee eligibility and to document its determination that an enrollee is a chronically ill enrollee based on the statutory definition codified in paragraph (f)(1)(i) of this section. We proposed to require plans to make information and documentation related to determining enrollee eligibility available to CMS upon request at § 422.102(f)(3)(ii). We explained in the proposed rule that the determination on the benefits an enrollee is entitled to receive under an MA plan's SSBCI is an organization determination that is subject to the requirements of part 422, subpart M, including the issuance of denial notices to enrollees.

We also explained how the proposal on SSBCI would codify already existing guidance and practices and therefore was not expected to have additional impact above current operating expenses. We also stated our belief that our proposal would not impose any collection of information requirements.

We thank commenters for helping inform CMS' SSBCI policy. We received approximately 62 comments on this proposal; we summarize these comments and our responses as follows:

Comment: A number of commenters supported CMS' proposal to allow MA plans to consider any chronic condition not identified on chronic condition list if that condition is life threatening or significantly limits the overall health or function of the enrollee. A commenter encouraged CMS to continue requiring MA plans to consider any enrollee with a condition identified on list to meet the statutory criterion of having one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee.

Response: We thank commenters for their feedback. In the April 24, 2019 HPMS memo and 2020 Call Letter, CMS indicated that it would consider any enrollee with a condition identified as a chronic condition in section 20.1.2 of Chapter 16b of the Medicare Managed Care Manual to meet the statutory criterion of having one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee. This was done in an effort to maintain a consistent standard in CMS policy for what is a chronic condition (for purposes of eligibility for SSBCI and for special needs plans for individuals with a severe or disabling chronic condition).

In this rule, we proposed that MA plans may consider any enrollee with a condition identified on the list of chronic conditions as determined by the panel as described in section 1859(b)(6)(B)(iii) to meet the statutory criterion of having one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee in an effort to also maintain this consistency. However, we recognize that there may be some conditions and/or a subset of conditions in a plan population that may meet the statutory definition of a chronic condition, but the chronic condition may not be present on the list of medically complex chronic conditions. Therefore, we also proposed that a plan may identify an enrollee as meeting this first criterion of the definition of chronically ill enrollee—that the enrollee have one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee—using a condition that is not on that list so long as the statutory (and proposed regulatory) standards are met. As stated in the proposed rule, we want to allow plans the flexibility to identify needs within their unique plan population and do not want to inadvertently prevent a plan from addressing a condition or need in their population that may not be on the list. We wish to allow plans the flexibility to continue to innovate around providing care for their specific plan populations. Thus, we are finalizing this aspect of our proposal, which is reflected in how § 422.102(f)(1)(i)(B) provides that the list published by CMS is a non-exhaustive list. We reiterate that, as we proposed, we intend this list to be the list of severe or disabling chronic conditions developed by the panel of technical advisors convened in accordance with section 1859(f)(9)(A)(i) of the Act. In addition to having one or more comorbid and medically complex conditions that is life threatening or significantly limits overall health and function, an enrollee must also have a high risk of hospitalization and require intensive care coordination to be considered chronically ill. Additionally, the covered item or service must have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.

Comment: Some commenters requested CMS provide additional guidance concerning the definition of the phrase ''intensive care coordination'' as it is used in the regulation.

Response: We expect MA plans to develop objective criteria (for example, health risk assessments, review of claims data, etc.) in determining SSBCI eligibility. We are not adopting a specific definition or standard for the statutory requirement that the chronically ill enrollee require intensive care coordination as the phrase is sufficiently clear for MA organizations to develop reasonable approaches in determining when it is met. We believe that objective criteria for determining what constitutes intensive care coordination are present in the medical community and readily accessible to the plan, such as the expertise of the plan medical director and plan physicians. We believe MA plans should have flexibility to determine what objective criteria to use when determining what meets the intensive care coordination criterion in their plan populations. However, we will keep this recommendation under advisement as we gain experience with SSBCI offerings.

Comment: A few commenters requested CMS allow plans to use functional status, rather than medical diagnoses, to determine whether an enrollee is eligible for SSBCI. A commenter stated that individuals with the same diagnosis may have different functional limitations and therefore different needs.

Response: We thank commenters for their feedback. We note that for the purposes of SSBCI, the statute requires the enrollee to have a chronic condition(s) that is life threatening or limits the overall health and function of an enrollee; this is in addition to the requirements that the enrollee have a high risk of hospitalization or other adverse health outcomes and require intensive care coordination to be eligible for SSBCI. Two of the required criteria refer to the function of the enrollee, so we believe it is sufficiently clear that this is something that can be considered when determining if an enrollee is a chronically ill enrollee.

Once meeting the criteria to be a chronically ill enrollee, and therefore eligible for SSBCI, the statute and our implementing regulation permit SSBCI that are designed to address the functional status of the enrollee. As discussed in the proposed rule, SSBCI must have a reasonable expectation of improving or maintaining the health or overall function of the enrollee. Thus, a plan may choose to provide an SSBCI that improves or maintains overall function of an enrollee who is eligible for SSBCI per the three-pronged definition.

Comment: Some commenters expressed concern that the new SSBCI policies could potentially undermine the role of SNPs in the Medicare Advantage program.

Response: SNPs are specifically designed to provide targeted care to special needs individuals. SNPs offer a wider array of specific interventions regarding their targeted population. Additionally, SNPs are required to develop and implement an evidence based model of care that provides structure for care management processes and systems that enables the plan to provide coordinated care for special needs individuals. We do not believe that the availability of SSBCI as permissible supplemental benefits undermines the specialized care model that SNPs provide. We believe that the MA program and the diverse needs of Medicare population have room for MA plans that are designed, as a whole, to address special needs populations and for specific benefits designed to improve or maintain the health or overall function of a specific chronically ill enrollee.

Comment: Some commenters expressed concern that the new benefit flexibilities, including the different eligibility requirements, could confuse enrollees.

Response: MA plans are required to provide enrollees with information on covered benefits, including SSBCI if the MA plan offers them, each year through the Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) documents. In addition, MA organizations must comply with the marketing and communications regulations in part 422, subpart V, when issuing any information regarding SSBCI to enrollees; these include prohibitions on MA organizations misleading beneficiaries, providing information that inaccurate, or engaging in activities that confuse beneficiaries. Consistent with MCMG requirements, it is our expectation that plans communicate information on SSBCI to enrollees in a clear manner about the scope of SSBCI that the MA plan covers and who is eligible for those benefits.

Comment: Several commenters requested that CMS ensure that these new benefit flexibilities for the chronically ill do not lead to discrimination against high-need beneficiaries.

Response: We thank commenters for sharing their concerns. We note that section 1852(b)(1)(A) of the Act prohibits an MA plan from denying, limiting, or conditioning the coverage or provision of a service or benefit based on health-status related factors. MA regulations (for example, §§ 422.100(f)(2) and 422.110(a)) reiterate and implement this non-discrimination requirement. In interpreting these obligations to protect against discrimination, we have historically indicated that the purpose of the requirements is to protect high-acuity enrollees from adverse treatment on the basis of their higher cost health conditions (79 FR 29843; 76 FR 21432; and 74 FR 54634). As MA plans implement these benefit flexibilities for SSBCI, they must be mindful of ensuring compliance with non-discrimination responsibilities and obligations.[5] Additionally, CMS reviews benefit designs to make sure that the overall impact is non-discriminatory and that higher acuity, higher cost enrollees are not being excluded in favor of healthier populations. Additionally, we believe it is important to note that in order to be eligible for SSBCI an enrollee must as stated above (1) have one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee; (2) have a high risk of hospitalization or other adverse health outcomes; and (3) require intensive care coordination. It is only enrollees with chronic conditions, as described by the three pronged definition above, that are eligible for these benefits. Thus, it is these individuals who are intended to receive these special benefits.

Comment: Commenters also requested CMS provide additional subregulatory guidance on SSBCI and supplemental benefits in general, including updating Managed Care Manuals. Although characterized as being in response to the proposal to change the costs that may be included in the definition of ''incurred costs'' for MLR purposes (addressed in section V.I. of the proposed rule and section IV.D of this final rule), other commenters noted how SSBCI are not always delivered by medical providers.

Response: We believe that our discussion in the proposed rule explaining the proposal we are finalizing provides extensive guidance for MA organizations on this topic. The April 2019 HPMS Memo and CY 2020 Call Letter address SSBCI and that guidance is still applicable as § 422.102(f), as proposed and as finalized, codifies significant portions of that guidance. CMS will consider additional subregulatory guidance, including manual updates, as the program develops. Additionally, as discussed in the 2020 Call Letter, we note that MA plans may contract with community-based organizations such as those providing other home and community-based services (HCBS) to provide supplemental benefits, including SSBCI, that are compliant with the statutory and regulatory requirements. For example, an MA plan could elect to offer, as a SSBCI, the provision of meals or food/produce and pay a community-based organization for furnishing the covered benefit. Community-based organizations can also help determine whether an individual meets the eligibility requirements for SSBCI. These organizations may already be providing services in the community and, in some cases, have contractual arrangements with Medicaid managed care or MA plans. We note that some community services programs are funded by the HHS Administration for Community Living (ACL) and utilizing ACL programs would also be permissible in delivering these supplemental benefits. This is consistent with the amendment to § 422.2420, discussed in section III.D.1 of this final rule, to include amounts paid for SSBCI to providers that are not necessarily healthcare professionals as incurred claims in the calculation of the MLR.

Comment: Some commenters requested CMS provide greater detail on allowable SSBCI including meals, transportation, and durable medical equipment (DME).

Response: A non-exhaustive list of examples of non-primarily health related, which includes meals (beyond a limited basis) and non-medical transportation SSBCI can be found in the April 2019 HPMS Memo and this preamble. However, we note the requirements around the SSBCI, which include the statutory authority for the Secretary to waive uniformity requirements and the statutory requirement that SSBCI have a reasonable expectation of improving or

[5] Among these responsibilities and obligations are compliance with Title VI of the Civil Rights Act, section 504 of the Rehabilitation Act, the Age Discrimination Act, section 1557 of the Affordable Care Act, and conscience and religious freedom laws.

maintaining the health or overall function of the chronically ill enrollee, allow significant of flexibility for MA plans to consider the needs of enrollees who meet the high standards in the definition of chronically ill enrollee and to design benefits to assist enrollees at an individualized level. We encourage MA plans to continue to consider the unique needs of their plan populations when proposing items or services that meet SSBCI conditions in their bid and submitted plan benefit package. As explained in the referenced April 2019 HPMS memo, MA plans have broad discretion in developing items and services they may offer as SSBCI provided that the item or service has a *reasonable* expectation of improving or maintaining the health or overall function of the chronically ill enrollee. Under our current guidance and this final rule, MA plans also have broad discretion in determining what may be considered 'a reasonable expectation' when choosing to offer specific items and services as SSBCI so long as the statutory standard is met.

Concerning DME, MA plans are required to ''provide coverage of, by furnishing, arranging for, or making payment for, all services that are covered by Medicare Part A and Part B'' (see 42 CFR 422.101(a)), which includes coverage of durable medical equipment, prosthetics and supplies. As discussed in the referenced HPMS memo, non-Medicare-covered safety devices to prevent injuries in the home or bathroom are considered primarily health related and may be offered as a supplemental benefit to all enrollees for whom the item is medically necessary. We remind MA organizations of our long-standing guidance in Chapter 4 of the Medicare Managed Care Manual about medical necessity in the context of supplemental benefits and how MA plans may develop their own medical necessity policies and procedures, so long as access to and coverage of Part A and Part B benefits is not more restrictive than Original Medicare. Other equipment that is not primarily health related may be considered as an SSBCI if it has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.

Comment: A few commenters suggested CMS allow plans to target some services to address social risk factors. A commenter suggested CMS test ways to provide more flexibility in targeting supplemental benefits to address social risk factors like homelessness.

Response: The statute does not authorize MA plans to offer and cover supplemental benefits, even SSBCI, based solely on social risk factors; the statute explicitly provides that eligibility for SSBCI is based on whether an enrollee meets the definition to be a chronically ill enrollee, which does not include a reference to social risk factors. As discussed in this preamble, MA plans can provide non-primarily health related supplemental benefits that address chronically ill enrollees' social determinants of health so long as the benefits have a reasonable expectation of maintaining or improving the health or function of that chronically ill enrollee. MA plans may consider social determinants of health as a factor to help identify chronically ill enrollees whose health could be improved or maintained with SSBCI. However, they may not use social risk factors as the sole basis for determining eligibility for SSBCI. Please note that the current CMS Innovation Center Medicare Advantage Value-Based Insurance Design (VBID) model allows participants to vary supplemental benefits based on chronic condition or socioeconomic status or a combination of the two. MA organizations have the option of participating in this model if they choose.

Comment: Some commenters suggested that information and documentation concerning SSBCI eligibility determinations should be reported more broadly, rather than only made available upon request. A commenter stated that this information would be necessary to better understand the efficacy of offered benefits.

Response: We thank commenters for their suggestions. At this time, we do not wish to place additional reporting burden on plans. However, we will take this comment under advisement as we continue to develop and refine SSBCI policy. Concerning the written policy requirements at § 422.102(f)(3)(i) and (iii), we clarify that these requirements concern the existence of such policies and that we do not intend to regularly review the content for compliance with the substantive standards of the regulation. We are implementing the statutory authority for SSBCI in a way to provide discretion and flexibility for MA plans, consistent with our approach to supplemental benefits design, within the statutory and regulatory limits. Per § 422.102(f)(3)(i), plans are required to have written policies for determining enrollee eligibility. As we explained in the CY 2020 Call Letter, maintaining detailed internal documentation is, at a minimum, necessary to address potential beneficiary appeals and complaints. However, MA organizations will have discretion in developing these policies. Additionally, per § 422.102(f)(3)(iii), plans are required have written policies based on objective criteria for determining a chronically ill enrollee's eligibility to receive a particular SSBCI and must document the criteria. We do not intend to closely monitor or regularly request these documentation and reiterate that MA plans will have discretion in designing which items and services to offer as SSBCI and for which chronically ill enrollees to cover them, so long as the statutory and regulatory standards are met.

Comment: Some commenters expressed concern that SSBCI are not available to individuals enrolled in Original Medicare. Other commenters suggested CMS test a model that includes original Medicare enrollees.

Response: The Balanced Budget Act of 1997 (BBA) authorized CMS to contract with public or private organizations to offer a variety of health plan options for beneficiaries. Under section 1852(a)(3)(D), MA plans are authorized to offer supplemental benefits, including SSBCI. The MA program has historically authorized MA plans to offer some form of additional or supplemental benefits to MA enrollees. Medicare beneficiaries choose to elect either original Medicare or an MA health plan that may have supplemental benefits. Concerning additional models, CMS appreciates this suggestion and will take it under consideration as we consider new Innovation Center models.

Comment: Several commenters suggested CMS study how many beneficiaries actually receive these benefits and not just how many are eligible for them in order to understand the actual impact of these new benefits.

Response: We appreciate this comment and will take this comment under consideration as we monitor how MA plans offer these benefits and continue to develop these policies.

We thank commenters for their feedback.

As discussed in this preamble, because SSBCI are supplemental benefits, they must also comply with our longstanding interpretation of the criteria for supplemental benefits; we also proposed to codify those criteria at § 422.100(c)(2)(ii), which was discussed in detail in section VI.F. of the proposed rule. We considered whether the regulation for SSBCI should explicitly reference the requirements in § 422.100(c)(2)(ii) to make this clear and solicited comment on this point. We received no comments on this specific subject.

After consideration of the comments received and for the reasons outlined in

the proposed rule and our responses to comments, we are finalizing § 422.102(f) largely as proposed. We are finalizing slight revisions to the regulation text, to eliminate a reference to § 422.100(c)(2)(i) in paragraph (f)(1)(ii) which was tied to the proposal regarding § 422.100(c)(2) that is not being addressed in this final rule. We are also correcting a typographical error in paragraph (f)(2)(iii).

B. Contracting Standards for Dual Eligible Special Needs Plan (D–SNP) Look-Alikes (§ 422.514)

Special needs plans (SNPs) are MA plans created by the MMA that are specifically designed to provide targeted care and limit enrollment to individuals with special needs. Under section 1859 of the Act, SNPs are able to restrict enrollment to: (1) Institutionalized individuals, who are currently defined in § 422.2 as those residing or expecting to reside for 90 days or longer in a long term care facility; (2) individuals entitled to medical assistance under a State Plan under Title XIX; or (3) other individuals with certain severe or disabling chronic conditions who would benefit from enrollment in a SNP. As of July 2019, there are 321 SNP contracts with 734 SNP plans that have at least 11 members, including all of the following:

- 480 dual eligible SNPs (D–SNPs).
- 125 institutional SNPs (I–SNPs).
- 129 chronic or disabling condition SNPs (C–SNPs).[6]

Beneficiaries who are dually eligible for both Medicare and Medicaid can face significant challenges in navigating the two programs, which include separate or overlapping benefits and administrative processes. Fragmentation between the two programs can result in a lack of coordination for care delivery, potentially resulting in—(1) missed opportunities to provide appropriate, high-quality care and improve health outcomes; and (2) undesirable outcomes, such as avoidable hospitalizations and poor beneficiary experiences. Advancing policies and programs that integrate care for dually eligible individuals is one way in which we seek to address such fragmentation. Under plans that offer integrated care, dually eligible individuals receive the full array of Medicaid and Medicare benefits through a single delivery system, thereby improving care coordination, quality of care, and beneficiary satisfaction, and reducing administrative burden. Some studies have shown that highly integrated managed care programs perform well on quality of care indicators and enrollee satisfaction.[7]

D–SNPs are intended to integrate or coordinate care for this population more effectively than standard MA plans or the original Medicare fee-for-service program by focusing enrollment and care management on dually eligible individuals. As of July 2019, approximately 2.6 million dually eligible individuals (1 of every 5 dually eligible individuals) were enrolled in 480 D–SNPs.

As summarized in our proposed rule, federal statute and implementing regulations have established several requirements for D–SNPs in addition to those that apply to all MA plans to promote coordination of care, including health risk assessment (HRA) requirements as described in section 1859(f)(5)(A)(ii)(I) of the Act and at § 422.101(f)(1)(i), evidence-based models of care (MOCs) as described in section 1859(f)(5)(A)(i) of the Act and at § 422.101(f), and state Medicaid agency contracts as described in section 1859(f)(3)(D) of the Act and at § 422.107. The state Medicaid agency contracting requirement allows states to require greater integration of Medicare and Medicaid benefits from the D–SNPs in their markets.

More recently, section 50311(b) of the BBA of 2018 amended section 1859 of the Act to add new requirements for D–SNPs, beginning in 2021, including minimum integration standards, coordination of the delivery of Medicare and Medicaid benefits, and unified appeals and grievance procedures for integrated D–SNPs, the last of which we implemented through regulation to apply to D–SNPs with exclusively aligned enrollment, termed ''applicable integrated plans.'' These requirements, along with clarifications to existing regulations, were codified in the April 2019 final rule (84 FR 15680 through 15844).

We discussed in the proposed rule and reiterate here the pattern of federal legislation, CMS rulemaking, and state use of D–SNP contracting requirements has incrementally created new requirements for D–SNPs that have generally promoted additional beneficiary protections, coordination of care, and integration of Medicare and Medicaid coverage for dually eligible individuals. While many of these requirements impose additional burdens for D–SNPs, they have not impeded enrollment growth in these plans. Total D–SNP enrollment has more than doubled from one million in 2010 to 2.6 million in 2019.[8] Participation of MA organizations is robust, and most markets are stable and competitive.

In this final rule, we address the emergence of ''D–SNP look-alike'' plans that are a hindrance to meaningful implementation of statutory requirements for D–SNPs, particularly those connected with the BBA of 2018. As the Medicare Payment Advisory Commission (MedPAC) described in its June 2018 and 2019 reports to Congress and as summarized in the proposed rule, D–SNP look-alikes have levels of dual eligible enrollment that are virtually indistinguishable from those of D–SNPs and far above those of the typical MA plan.

As discussed in the proposed rule, we believe the low enrollment of non-dually eligible individuals in D–SNP look-alikes results from benefits and cost-sharing that, like the benefits and cost-sharing offered by D–SNPs, are designed to attract only dually eligible individuals. In contrast to non-SNP MA plans, both D–SNPs and D–SNP look-alikes allocate a lower percentage of MA rebate dollars received under the bidding process at § 422.266 to reducing Medicare cost-sharing and a higher percentage of rebate dollars to supplemental medical benefits such as dental, hearing, and vision services. With such a benefit design, many D–SNP look-alikes technically require members to pay higher cost sharing for Parts A and B services than most MA plans require, which we believe dissuades most non-dually eligible

[6] Centers for Medicare & Medicaid Services. *SNP Comprehensive Report.* (July 2019) Retrieved from *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html.*

[7] See Kim, H., Charlesworth, C.J., McConnell, K.J., Valentine, J.B., and Grabowski, D.C. ''Comparing Care for Dual-Eligibles Across Coverage Models: Empirical Evidence From Oregon'', *Medical Care Research and Review,* (November 15, 2017) 1–17. Retrieved from *http://journals.sagepub.com/doi/abs/10.1177/1077558717740206*;

Anderson, W.L., Feng, Z., & Long, S.K. *Minnesota Managed Care Longitudinal Data Analysis,* prepared for the U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE) (March 31, 2016). Retrieved from *https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis*;

Health Management Associates. *Value Assessment of the Senior Care Options (SCO) Program* (July 21, 2015). Retrieved from *http://www.mahp.com/wp-content/uploads/2017/04/SCO-White-Paper-HMA-2015_07_20-Final.pdf*; and

Medicare Payment Advisory Committee. ''Chapter 2, Care coordination programs for dual-eligible beneficiaries.'' In *June 2012 Report to Congress: Medicare and Health Care Delivery System* (June 16, 2012). Retrieved from *http://www.medpac.gov/docs/default-source/reports/jun12_entirereport.pdf?sfvrsn=0.*

[8] Centers for Medicare & Medicaid Services. *SNP Comprehensive Report* (July 2010 & July 2019). Retrieved from *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html.*

Medicare beneficiaries from enrolling. However, because most dually eligible individuals are Qualified Medicare Beneficiaries (QMBs) who are not required to pay Medicare cost sharing under sections 1848(g)(3) and 1866(a)(1)(A) of the Act, we believe they are not dissuaded from enrolling in these non-D–SNPs by the relatively higher cost sharing. A similar dynamic exists for Part D premiums and high deductibles, both of which are covered by the Part D low-income subsidy that dually eligible individuals receive. We believe that such benefit designs are unattractive for Medicare beneficiaries who are not dually eligible individuals because they would need to cover these costs out-of-pocket. Despite the similarities with D–SNPs in terms of levels of dual eligible enrollment and benefits and cost-sharing design, D–SNP look-alikes are regulated as non-SNP MA plans and are not subject to the federal regulatory and state contracting requirements applicable to D–SNPs.

As summarized in the proposed rule, the proliferation and growth of D–SNP look-alikes raises concerns related to effective implementation of the BBA of 2018 requirements; meaningful integration of Medicare-and Medicaid programs via state Medicaid agency contracting; care coordination through HRAs; evidence-based MOCs; and beneficiary confusion stemming from misleading marketing practices by brokers and agents that misrepresent to dually eligible individuals the characteristics of D–SNP look-alikes. We direct readers to the proposed rule, 85 FR 9018 through 9021, for a more detailed discussion of D–SNP look-alikes and their impact on implementation of D–SNP Medicare and Medicaid integration.

Under our authority to adopt standards implementing the Part C statute and to add contract terms in sections 1856(b) and 1857(e)(1) of the Act, we proposed establishing contracting standards at § 422.514 for MA organizations based on their projected dually eligible enrollment in plan bids or on the proportion of dually eligible enrollees actually enrolled in the MA plan. As discussed in the proposed rule, a high rate of enrollment by dually eligible individuals in a non-D–SNP would allow us to identify non-SNP MA plans that are intended to predominantly enroll dually eligible individuals (that is, D–SNP look-alikes). To prevent the undermining of the statutory and regulatory framework for D–SNPs, we proposed a new regulation precluding CMS from entering into or renewing a contract for an MA plan that an MA organization offers, or proposes to offer, with enrollment of dually eligible individuals that exceeds specific enrollment thresholds (85 FR 9021–9025). We also proposed that the regulation apply in any state where there is a D–SNP or any other plan authorized by CMS to exclusively enroll dually eligible individuals.

As described in our proposal, we would not enter into or renew MA contracts for an MA plan for an upcoming plan year if that MA plan exceeds specific enrollment thresholds for dually eligible individuals. However, MA organizations with plans exceeding the enrollment threshold that also have approved D–SNPs for the following plan year would be permitted to transition dually eligible enrollees from D–SNP look-alikes to D–SNPs for which the individuals are eligible. We proposed this transition process to minimize disruptions to beneficiary coverage and allow enrollees in these D–SNP look-alikes to benefit from the statutory and regulatory care coordination and Medicaid integration requirements. We describe the specific proposed changes to § 422.514 as follows.

We proposed changing the title of § 422.514 by removing the word ''minimum'' because the changes we proposed to § 422.514 reflect an additional type of enrollment requirement beyond the minimum enrollment requirements currently articulated in § 422.514. We also proposed changing the title of paragraph (a) from ''Basic rule'' to ''Minimum enrollment rules'' for clarity due to the proposed change to the scope of § 422.514.

We proposed adding a new paragraph (d) to establish new contract requirements related to dual eligible enrollment. The proposed requirement at paragraph (d) would apply for an MA plan that is not a special needs plan for special needs individuals as defined in § 422.2. We explained our rationale in depth for this approach in the proposed rule.

We proposed to limit the requirement at paragraph (d) to states where there is a D–SNP or any other plan authorized by CMS to exclusively enroll dually eligible individuals, such as Medicare-Medicaid Plans (MMPs). We proposed this limitation because it is only in such states that the implementation of D–SNP requirements necessitates our proposed new contracting requirements. That is, in a state with no D–SNPs or comparable managed care plans like MMPs, the D–SNP requirements have not had any relevance historically, as there are no plans contracted with the state to implement the D–SNP requirements or otherwise integrate Medicare and Medicaid services. Therefore, the operation of a D–SNP look-alike would not have any material impact on the full implementation of federal D–SNP requirements. In such states, the existence of D–SNP look-alikes is not impeding state or federal implementation of any requirements for enhanced care coordination and Medicaid integration by providing a vehicle for MA organizations to avoid compliance with those requirements that are imposed on D–SNPs or comparable managed care plans like MMPs. We also noted the limited number of states—eight, as of July 2019—with no D–SNPs. Therefore, we expressed our belief that it is not critical for our proposed requirements in paragraph (d) to apply in such states. We solicited comment on whether the absence of these data sharing and care coordination requirements for D–SNP look-alikes in states where they could continue to operate under our final rule disadvantages the dually eligible individuals in D–SNP look-alikes and whether we should extend the proposed requirement at paragraph (d) to all states.

We proposed new paragraphs (d)(1) and (2) that would require that CMS not enter into or renew a contract, for plan year 2022 or subsequent years, for an MA plan that is a non-SNP plan that either:

- Projects in its bid submitted under § 422.254 that 80 percent or more of the plan's total enrollment are enrollees entitled to medical assistance under a state plan under Title XIX, or
- Has actual enrollment, as determined by CMS using the January enrollment of the current year, consisting of 80 percent or more of enrollees who are entitled to medical assistance under a state plan under Title XIX, unless the MA plan has been active for less than one year and has enrollment of 200 or fewer individuals at the time of such determination.

We explained that using each enrollment scenario is necessary to ensure that both new D–SNP look-alikes are not offered and that current, or existing, D–SNP look-alikes are not continued. We proposed a threshold for dually eligible enrollment at 80 percent of a non-SNP MA plan's enrollment because it far exceeds the share of dually eligible individuals in any given market and, therefore, would not be the result for any plan that had not intended to achieve high dually eligible enrollment. As detailed in the proposed rule, MedPAC data show that our proposed threshold would have minimal impact on total dually eligible enrollment in non-SNP MA plans.

As discussed in the proposed rule, we considered an alternative discussed by MedPAC in its June 2019 report to Congress for identifying traditional MA plans with predominantly dually eligible enrollment: Setting the bar at the higher of 50 percent dually eligible enrollment or the proportion of dually eligible MA-eligible individuals in the plan service area plus 15 percentage points. We also considered setting a lower threshold for dually eligible enrollment at a point between 50 percent and our 80 percent threshold. However, as explained in the proposed rule, we proposed an enrollment threshold of 80 percent or higher as an indicator that the plan is designed to attract disproportionate dually eligible enrollment because it aligns with MedPAC's 2019 research findings, provides a threshold that would be easier for MA organizations to determine prospectively, and would be operationally easier for CMS to implement. We solicited comment on these alternative enrollment thresholds.

Under our proposal for paragraph (d)(2), we proposed making the annual determination whether an MA organization has a non-SNP MA plan with actual enrollment exceeding the established threshold using the plan's enrollment in January of the current year in order to make such evaluations and issue the necessary information to affected MA organizations sufficiently early in the year for MA organizations to have time to take the necessary steps to adjust other plan offerings before the point at which CMS would decline to renew the contract for an MA plan—which effectively (and as described later in this section) would result in the non-renewal (that is, termination) of the D–SNP look-alike plan benefit package. Proposed paragraph (d)(2) would also limit the prohibition to MA plans that have been active for one or more years and with enrollment greater than 200 individuals at the time of CMS' determination under proposed paragraph (d)(2).

In paragraph (e), we proposed processes and procedures for transitioning individuals who are enrolled in a D–SNP look-alike to another MA–PD plan (or plans) offered by the MA organization to minimize disruption as a result of the prohibition on contract renewal for existing D–SNP look-alikes. Under our proposal, an MA organization with a non-SNP MA plan determined to meet the enrollment threshold in proposed paragraph (d)(2) could transition enrollees into another MA–PD plan (or plans) offered by the same MA organization, as long as any such MA–PD plan meets certain proposed criteria. This proposed transition process would allow MA enrollees to be transitioned from one MA plan offered by an MA organization to another MA–PD plan (or plans) without having to fill out an election form or otherwise indicate their enrollment choice as typically required, but it would also permit the enrollee to make an affirmative choice for another MA plan of his or her choosing.

In proposed paragraph (e)(1), we specified that, for coverage effective January 1 of the next year, the MA organization could only transition individuals from the D–SNP look-alike that is not being renewed into one or more MA plans (including a D–SNP) if such individuals are eligible to enroll in the receiving plan(s) in accordance with §§ 422.50 through 422.53. Thus, the individual would have to reside in the service area of the new plan and otherwise meet eligibility requirements for it. The proposed transition process would allow, but not require, the MA organization to transition dually eligible enrollees from a D–SNP look-alike into one or more D–SNPs offered under the MA organization, or another MA organization that shares the same parent organization as the MA organization, and therefore allow enrollees to benefit not only from continued coverage under the same parent organization but also from the care coordination and Medicaid benefit integration offered by a D–SNP.

We also proposed at paragraphs (e)(1)(i) through (iii) specific criteria for any MA plan to receive enrollment through this transition process to ensure that enrollees receive coverage under their new MA plan that is similarly affordable as the plan that would not be permitted for the next year:

- Under proposed paragraph (e)(1)(i), we would allow a non-renewing D–SNP look-alike to transition enrollment to another non-SNP plan (or plans) only if the resulting total enrollment in each of the MA plans receiving enrollment consists of less than 80 percent dually eligible individuals. SNPs receiving transitioned enrollment would not be subject to this proposed limit on dual eligible enrollment. As described in the proposed rule, the percent of dually eligible individuals in the resulting total enrollment would have to be determined prospectively in order for us to make a timely decision on whether to allow for an MA organization to transition enrollment into a non-SNP MA plan or plans. Under proposed paragraph (e)(3), we would make such determination by adding the cohort of enrollees that the MA organization proposes to enroll into a different non-SNP plan to the April enrollment of the receiving plan and calculating the resulting percent of dually eligible enrollment. As discussed in the proposed rule, we would make this calculation for each non-SNP plan into which the MA organization proposes to transition enrollment in order to ensure that the enrollment transitions do not result in another non-SNP MA plan being treated as a D–SNP look-alike.
- Under proposed paragraph (e)(1)(ii), we would require that any plan receiving transitioned enrollment be an MA–PD plan as defined in § 422.2.
- Under proposed paragraph (e)(1)(iii), any MA plan receiving transitioned enrollment from a D–SNP look-alike would be required to have a combined Part C and D beneficiary premium of $0 after application of the premium subsidy for full subsidy eligible individuals described at § 423.780(a).

As proposed in paragraph (e)(2)(ii), the MA organization would be required to describe changes to MA–PD benefits and provide information about the MA–PD plan into which the individual is enrolled in the Annual Notice of Change (ANOC) that the MA organization must send, consistent with § 422.111(a), (d), and (e) and proposed § 422.2267(e)(3). Consistent with § 422.111(d)(2), enrollees would receive this ANOC describing the change in plan enrollment and any differences in plan enrollment at least 15 days prior to the first day of the annual election period (AEP).

As proposed in paragraph (e)(4), in cases where an MA organization does not transition some or all current enrollees from a D–SNP look-alike plan to one or more of the MA organization's other plans as provided in proposed paragraph (e)(1), it would be required to send affected enrollees a written notice consistent with the non-renewal notice requirements at § 422.506(a)(2).

As discussed in more detail in the proposed rule preamble, this proposed transition process is conceptually similar to ''crosswalk exception'' procedures historically allowed by CMS and proposed at § 422.530 in the notice of proposed rulemaking. However, in contrast to the proposed crosswalk exceptions, our proposal would allow the transition process to apply across legal entities offered by MA organizations under the same parent organization, as well as between non-SNP plans and SNPs. Because this transition process is not the same as the crosswalk process, we proposed to codify it as part of § 422.514.

In the proposed rule, we explained how we also considered an alternative

that would require transitioning any dually eligible individuals into a D–SNP for which they were eligible if such a plan is offered by the MA organization. In addition, we solicited comment on whether additional criteria for the receiving plan are necessary to protect beneficiaries who are affected by this proposed prohibition on renewing MA plans that meet the criteria in proposed § 422.514(d).

We described in the proposed rule our intent for the transition process to take effect in time for D–SNP look-alikes operating in 2020 to utilize the transition process for enrollments to be effective January 1, 2021. This will allow current MA–PD plans that expect to meet the enrollment threshold in proposed paragraph (d)(2) to retain some or all of their current enrollment by transitioning these individuals to other MA–PD plans offered by the same MA organization a year before CMS implements any contracting limitations under this proposal.

Overall, our proposed rule focused on dually eligible individuals as a percentage of an MA plan's total enrollment. We considered using alternative criteria instead of, or in addition to, the percentage of projected or actual dually eligible enrollment, to identify non-SNP MA plans designed to exclusively or predominantly enroll dually eligible individuals. In particular, we considered identifying D–SNP look-alikes by the benefit design these plans typically offer—relatively high Parts A and B cost sharing and a high Part D deductible that make the plans unattractive to Medicare-only beneficiaries, supplemental benefits like dental and hearing services and over-the-counter drugs that mimic typical D–SNP offerings, and a premium for Part D coverage that is fully covered by the Part D low-income subsidy. We also considered using the percentage of MA rebate dollars allocated to buy down Parts A and B cost sharing compared to other supplemental benefits—D–SNP look-alikes typically allocate a greater percentage to the latter—as a way to identify D–SNP look-alikes. We explained in the proposed rule why we did not propose those alternatives but solicited comment on whether these alternative criteria should be used instead of, or in addition to, the criteria for identifying D–SNP look-alikes and applying contracting prohibition.

We received the following comments on these proposed contract requirements and respond to them below:

Comment: Many commenters expressed strong support for our proposal to preclude CMS from entering into or renewing a contract for an MA plan that an MA organization offers, or proposes to offer, with enrollment of dually eligible individuals that exceeds a specific threshold. Several commenters agreed with CMS that D–SNP look-alikes are an impediment to Medicare-Medicaid integration and meaningful implementation of federal and state requirements, including the new statutory requirements for D–SNPs under the BBA of 2018. A commenter appreciated that the proposal would, in most states, ensure that any entity whose enrollment consists mainly of dually eligible individuals follows the standards Congress established for MA plans serving dually eligible individuals. Several commenters agreed with MedPAC's 2018 and 2019 analyses, cited by CMS in the proposed rule preamble, that the proliferation of D–SNP look-alikes negatively impacts integrated care programs for dually eligible individuals. Some commenters believed the proposal would ultimately improve access to integrated care for dually eligible individuals. Several commenters also believed that D–SNPs were in the best position to serve the dually eligible population because of the D–SNP MOC, including care coordination and case management, which is not required of D–SNP look-alikes.

Several commenters also supported the proposed regulation because of their concern about how D–SNP look-alikes operate. A number of commenters expressed concern about D–SNP look-alikes marketing to dually eligible individuals in ways that misrepresent the plans' ability to integrate Medicare and Medicaid services. Several commenters noted that while D–SNP look-alikes advertise that they integrate care, they are not designed to serve the needs of dually eligible individuals nor required to do so. For these reasons, many commenters believed look-alikes confuse dually eligible individuals about their coverage options and lead to beneficiary harm.

Response: We appreciate the widespread support we received for our proposal. Many of the commenters' concerns about D–SNP look-alikes mirror the comments discussed in the 2020 Final Call Letter [9] and summarized in the proposed rule preamble. We believe that the contracting requirement we are finalizing in this rule will address these concerns and ensure the meaningful implementation of the new Medicare-Medicaid integration requirements under the BBA of 2018, along with other state and federal requirements. As discussed in the proposed rule and our responses to other comments, the prohibition will not apply to D–SNP look-alikes in states where there is a D–SNP or plan authorized by CMS to exclusively enroll dually eligible individuals.

Comment: A few commenters expressed support for CMS' efforts to integrate care but had concerns about the proposed contracting standard. Some commenters noted that the proposed rule may disrupt services and benefits for beneficiaries enrolled in D–SNP look-alikes. These commenters cautioned CMS to attend to continuity of care, the nuances of state requirements, and market dynamics as this final rule is implemented.

Response: We thank these commenters for their comments. We believe that the requirements we are finalizing in this rule, described in more detail later in this section, strike a balance between allowing for continuity of care for beneficiaries and promoting integrated care. In particular, as discussed later in this section, we are delaying implementation of D–SNP look-alike contract limitations for one additional year to provide sufficient time for MA organizations to develop and seek approval for new plans, coordinate with state integrated care efforts, and facilitate a transparent and smooth transition of beneficiaries. With a technical clarification described later in this section, we are finalizing our proposed transition approach for D–SNP look-alikes to transition enrollees into an MA plan or plans meeting certain criteria within the same parent organization to promote continuity of care.

Comment: Several commenters opposed our proposal to limit enrollment of dually eligible individuals in non-SNP MA plans. Some commenters noted that D–SNP look-alikes were created in response to states' contracting policies like those of California that restricted D–SNPs. A commenter questioned the need to regulate D–SNP look-alikes, citing the June 2019 MedPAC finding that only a small portion of traditional MA plans have dual eligible enrollment that comprises 80 percent or more of total plan membership.[10]

Some commenters believed that our proposal limited competition between MA plans that could lead to higher

[9] Available at *https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.*

[10] See *June 2019 MedPAC Report to Congress, Chapter 12* at *http://www.medpac.gov/docs/default-source/reports/jun19_ch12_medpac_reporttocongress_sec.pdf?sfvrsn=0.*

quality, innovative care, additional supplemental benefits, and improved provider network access for dually eligible individuals. A commenter stated that competition from D–SNP look-alikes targeted by our proposal has not hurt D–SNPs, noting that total D–SNP enrollment has more than doubled from one million in 2010 to 2.6 million in 2019.

A few commenters believed that D–SNP look-alikes fill critical gaps in markets where D–SNPs and MMPs are not available. Some commenters also believed that D–SNP look-alikes provide access to supplemental benefits and increased levels of care management, particularly for partial-benefit dually eligible individuals. These commenters were concerned that if the proposed contracting standard was implemented, D–SNP look-alike enrollees would lose access to these benefits and may return to the original Medicare fee-for-service program, which does not coordinate with Medicaid. A few commenters requested that, prior to finalizing any rule on D–SNP look-alikes, CMS perform a more detailed analysis of available options and impacts of the proposal on enrollees, both full- and partial-benefit dually eligible individuals, such as loss of benefits.

Several commenters expressed concern that CMS' proposed contracting standard would unnecessarily limit beneficiary choice. A few commenters requested that CMS explain how the value of choice was taken into account for this proposal. Other commenters encouraged CMS to continue to promote consumer choice and provide dually eligible beneficiaries with an array of plan options that allow individuals to choose how to best meet their health care needs. A commenter noted that the need for beneficiary choice was supported by the June 2018 MedPAC finding that 64 percent of partial-benefit dually eligible MA enrollees were enrolled in traditional MA plans in 2016,[11] and that a large percentage of full-benefit dually eligible individuals passively enrolled in MMPs also have indicated a preference for choice by opting out of MMP enrollment.

Response: We thank the commenters for the feedback on our proposal. We maintain that MA plans with enrollment exclusively, or predominantly, consisting of dually eligible individuals—the principal criterion that distinguishes D–SNPs from other MA plans in statute—should be subject to the federal regulatory and state contracting requirements that are applicable to D–SNPs. We note that, despite D–SNP regulations promulgated since 2006, MA organization participation in the D–SNP program is robust. Most D–SNP enrollment is in markets that feature numerous other plan choices for beneficiaries, and enrollment in D–SNPs has continued to increase. We also note that while state contracting policies may have been the impetus for some sponsors to create D–SNP look-alikes, states are authorized to play a role in coordinating Medicaid benefits with MA plans that exclusively enroll dually eligible individuals, as described in section 164 of MIPPA, which amended section 1859(f) of the Act. Therefore, if our proposal leads to any change in the degree of beneficiary choice, such impact would be marginal, and we believe the benefits from our proposal—described here and in the proposed rule—outweigh any such impact.

We agree with the commenter that D–SNP look-alikes are currently a small number of all MA plans; however, D–SNP look-alikes' growth—both in terms of the number of plans offered and their total enrollment—is concerning, especially given Congress' requirements in the BBA of 2018 to further integrate Medicare and Medicaid benefits through D–SNPs. As noted in our proposed rule preamble, MedPAC found that D–SNP look-alike enrollment in California markets grew from around 5,000 in 2013 to over 95,000 in 2017.[12] MedPAC also explored enrollment trends more broadly, identifying 31 non-SNP plans [13] operating in 2017 in which dually eligible individuals comprised 80 percent or more of total plan enrollment. These 31 plans, which operated in 10 states, included approximately 151,000 enrollees. MedPAC estimated that in 2019 enrollment would increase to 193,000 beneficiaries in 54 D–SNP look-alikes across 13 states.[14]

We acknowledge the commenters' concerns about reducing access to supplemental benefits for D–SNP look-alike members and beneficiary choice, particularly for partial-benefit dually eligible individuals. However, as we stated in the proposed rule, we chose not to propose regulating benefit design to avoid inadvertently diminishing benefit flexibility that genuinely improves competition and beneficiary choice. We also note that most D–SNP look-alike enrollment is in markets that feature numerous other plan choices for beneficiaries, including D–SNPs that offer similar benefits; therefore, D–SNP look-alikes are not generally filling gaps in most of their markets nor significantly contributing to beneficiary choice. The majority of D–SNP look-alikes will be able to transition enrollees into another MA plan under the process described at § 422.514(e) of this final rule; therefore, we project that few D–SNP look-alike enrollees will be enrolled by default in the original Medicare fee-for-service program when this regulation limits the continued offering of a D–SNP look-alike.

We also note the contracting standard that we proposed and are finalizing does not apply to MA plans in states without D–SNPs or other plans authorized by CMS to exclusively enroll dually eligible individuals, further limiting the impact of this provision on access to supplemental benefits or beneficiary choice. Of the seven states that do not contract with D–SNPs or other plans authorized to exclusively enroll dually eligible individuals, only two have D–SNP look-alikes. As discussed in response to other comments on this topic, we will continue to engage with stakeholders to identify issues related to choice and access to supplemental benefits.

Comment: A commenter suggested that CMS work with states to provide multiple integrated care options for dually eligible individuals as an alternative to limiting D–SNP look-alikes. Another commenter requested that if CMS decides to implement the proposal, we should also require states to contract with D–SNPs.

Response: We note that section 164(c)(4) of MIPPA does not in any way obligate states to contract with a D–SNP; therefore, CMS does not have the authority to mandate states to contract with D–SNPs, and states have significant control over the availability of D–SNPs. We generally agree that increasing the number of integrated care options for dually eligible individuals is desirable, and CMS will continue to work with states to identify ways to integrate Medicare and Medicaid benefits in a way that best serves the states' dually eligible population. We also provide technical assistance to states on integration issues, including

[11] See *June 2018 MedPAC Report to Congress, Chapter 9* at *http://medpac.gov/docs/default-source/reports/jun18_ch9_medpacreport_sec.pdf?sfvrsn=0.*

[12] See *June 2018 MedPAC Report to Congress, Chapter 9* at *http://medpac.gov/docs/default-source/reports/jun18_ch9_medpacreport_sec.pdf?sfvrsn=0.*

[13] MedPAC also excluded employer group waiver plans (EGWPs) and a select group of medical savings account (MSA) plans.

[14] See *June 2018 MedPAC Report to Congress, Chapter 9* at *http://medpac.gov/docs/default-source/reports/jun18_ch9_medpacreport_sec.pdf?sfvrsn=0* and *June 2019 MedPAC Report to Congress, Chapter 12* at *http://www.medpac.gov/docs/default-source/reports/jun19_ch12_medpac_reporttocongress_sec.pdf?sfvrsn=0.*

through the Integrated Care Resource Center (see *https://www.integratedcareresourcecenter.com/*).

Comment: Several commenters supported our proposed approach in paragraph (d) to limit the availability of D–SNP look-alikes only in those states where there is a D–SNP or any other plan authorized by CMS to exclusively enroll dually eligible individuals. These commenters stated that look-alikes provide valuable supplemental benefits to dually eligible individuals that would not be available in a traditional MA benefit design in those states without D–SNP or MMP options. Some commenters further agreed with our rationale in the proposed rule that, in states without D–SNPs or comparable managed care plans (like MMPs), the existence of D–SNP look-alikes is not impeding full implementation of D–SNP integration requirements. A number of commenters recommended that our proposal to limit availability of D–SNP look-alikes apply only in counties where there are no D–SNPs or other plans authorized to exclusively enroll dually eligible individuals. A commenter agreed with CMS' observation that operating MA plans in rural areas presents a challenge to MA plan operations, including for D–SNPs. This commenter stated that, in those rural areas without D–SNPs or other plans authorized by CMS to exclusively enroll dually eligible individuals, eliminating MA plan options can harm rather than benefit dually eligible individuals, and in the absence of integrated plan options, access to D–SNP look-alikes should be preserved.

Response: We appreciate these commenters' support of the proposed limit on this policy to states where there is a D–SNP or any other plan authorized by CMS to exclusively enroll dually eligible individuals, such as an MMP. In our proposed rule we noted that, as of July 2019, seven states did not have D–SNPs or other plans authorized by CMS to exclusively enroll dually eligible individuals. In these states, there are no plans contracted with the state to implement the D–SNP requirements or otherwise integrate Medicare and Medicaid services, and therefore the operation of a D–SNP look-alike would not have any immediate material impact on the full implementation of federal D–SNP requirements. In such states, the existence of D–SNP look-alikes is not impeding federal or state implementation of any requirements for enhanced care coordination and Medicaid integration by providing a vehicle for MA organizations to avoid compliance with those requirements that are imposed on D–SNPs or comparable managed care plans like MMPs.

We disagree with the recommendation to further limit the proposed D–SNP look-alike policy to those counties where a D–SNP or comparable managed care plan like an MMP currently exists. From our work with states on Medicare-Medicaid integration, we recognize that states often proceed incrementally, contracting first for integrated managed care plans in certain counties before incorporating more areas or going statewide. We believe that allowing D–SNP look-alikes to precede D–SNPs or other more integrated plans in these markets would hinder expansion of state efforts to expand integrated managed care. In addition, we believe it would be more complicated for CMS to administer, MA organizations to comply with, and consumers to understand, if there was a county-by-county limitation on D–SNP look-alike availability.

With respect to the comments about contracting in rural areas, we understand that operating MA plans, including D–SNPs, can be a challenge in areas where the Medicare population is sparse and establishing networks is difficult. As discussed in section V.A. of this preamble, we are taking steps to improve access to managed care in rural areas through changes in network adequacy assessments. We will continue to monitor the volume of MA plans, including D–SNPs, offered in rural areas.

Comment: A commenter requested that CMS exempt from our proposed dual eligible enrollment rules in paragraph (d) D–SNP look-alikes in states that require the parent organization of the D–SNP to have a Medicaid contract with the state. The commenter expressed concern that implementing the rule as proposed would have an anticompetitive effect of locking out new plan entrants in such states.

Response: We disagree with the commenter that implementing paragraph (d) as proposed would reduce competition by not allowing new plan entrants in those states that limit D–SNP approval to parent organizations that have existing Medicaid contracts. As discussed in our April 2019 final rule in implementing the BBA of 2018, we sought to maintain existing state flexibility to promote integrated care for dually eligible individuals. As discussed earlier in this section, section 164 of MIPPA, which amended section 1859(f)(3)(D) of the Act, does not mandate that states contract with D–SNPs. The ability of states to determine the entities with which they enter into D–SNP contracts has been a core tenet for coordinating care between Medicare and Medicaid. We support efforts by states to further the integration of care coordination continuum and believe that the benefit from such coordination, in fact, increases competition to develop and win integrated products (that is, Medicaid contracts).

Comment: Many commenters stated that the dual eligible enrollment requirement should apply in all states to discourage the proliferation of plans that are not truly integrated and that offer limited or no care coordination. Several commenters noted that D–SNP look-alikes may detract from state efforts to coordinate care for dually eligible individuals, such as managed fee-for-service models. These commenters believed that states that do not contract with D–SNPs or MMPs should be able to exercise oversight and have freedom to set a broader strategy to coordinate care for their dually eligible population without worrying about the proliferation of D–SNP look-alike products. A commenter stated that proliferation of D–SNP look-alikes may discourage states from future contracting with D–SNPs and gives plans no incentive to introduce D–SNPs. This commenter noted that CMS and states need to work together to improve the way they serve dually eligible individuals because such individuals include the highest need, highest cost Medicare and Medicaid beneficiaries, and limiting D–SNP look-alike regulation to only some states impedes progress toward that end.

Response: We appreciate the commenters' perspective on this issue. We believe that our proposal as finalized strikes a balance between prohibiting look-alikes and allowing them to continue in states without D–SNPs or any other plan authorized by CMS to exclusively enroll individuals entitled to medical assistance under a state plan under Title XIX. We do not believe that in such states, the existence of look-alikes is materially impeding state or federal implementation of any requirements for enhanced care coordination and Medicaid integration or providing a vehicle for MA organizations to avoid compliance with those requirements that are imposed on D–SNPs or comparable managed care plans like MMPs. We recognize that substantial enrollment in D–SNP look-alikes in these states can alter the landscape if any of these states decides to begin contracting with D–SNPs. However, we believe state policy can accommodate these changes, for example, by contracting with MA organizations offering look-alikes to offer D–SNPs, enabling the transition of

look-alike enrollees into more integrated plans. We continue to collaborate and work with all states to strengthen integrated care, and we will monitor the penetration of MA plans as we continue to promote integrated care. As discussed in our proposed rule, we believe the limitation on the states where the dual eligible enrollment requirement applies will continue to protect states' ability to contract with plans—including for Medicaid behavioral health services and long-term supports and services (LTSS)—in a manner that promotes integration and coordination of benefits and a more seamless experience for dually eligible individuals in such plans. Therefore, in this final rule, we decline to expand our dual eligible enrollment requirements to plans operating in such states. However, we will continue to monitor D–SNP look-alikes in these states and consult with state officials about their impact on dually eligible individuals and state policy objectives.

Comment: Many commenters requested that CMS clarify whether the proposed 80 percent threshold for dual eligible enrollment in a non-SNP plan included both individuals entitled to full Medicaid benefits and individuals entitled to partial Medicaid benefits, such as state payment of Medicare Part B premiums or payment of Medicare premiums and cost sharing.

Response: Our proposed regulatory language in paragraph (d) regarding ''enrollees who are entitled to medical assistance under a state plan under title XIX'' is the same language used in section 1859(b)(6)(B)(ii) of the Act and in § 422.2 to define the population of special needs individuals D–SNPs may exclusively enroll. This language includes both full- and partial-benefit dually eligible individuals. Therefore, we clarify here that our proposed threshold for dual eligible enrollment—which we are finalizing in this rule—included both full- and partial-benefit dually eligible individuals.

Comment: A commenter recommended that our regulatory language in paragraph (d) be modified to refer to individuals who are ''entitled to and enrolled in medical assistance,'' since plans only know which enrollees actually receive Medicaid benefits, not those whose income levels might qualify them for such benefits.

Response: While we appreciate the commenter's concern, we believe that the language in § 422.514(d)(1) (individuals ''entitled to medical assistance'' under a state plan under Title XIX) sufficiently refers to individuals who have been determined to be entitled to medical assistance by virtue of having been enrolled in medical assistance under a state plan under Title XIX. That is our intent and interpretation of this language in § 422.514(d).

Comment: Some commenters recommended that the final rule not count any partial-benefit dually eligible individuals toward the threshold, while maintaining the threshold at 80 percent, in order to minimize the potential disruption caused by the non-renewal of D–SNP look-alikes, including D–SNP look-alikes in contracts with high Star Ratings. Other commenters supported setting the threshold at 80 percent if it applied only to full-benefit dually eligible individuals. Some commenters recommended that the threshold consist only of the categories of dually eligible individuals who were allowed to enroll in a D–SNP in any given market, defined at either the state or county level.

In contrast, other commenters supported counting enrollment of partial-benefit dually eligible individuals toward the 80 percent threshold. A commenter wrote that exclusion of partial-benefit dually eligible individuals while maintaining the threshold at 80 percent would drastically reduce the number of D–SNP look-alikes captured by the proposed regulation and potentially render the entire proposal ''meaningless.''

Response: We disagree with the recommendation to exclude partial-benefit dually eligible individuals from the enrollment threshold and agree with those commenters who believed such an exclusion would render the proposal less effective. Such an exclusion would allow 32 of the 64 non-SNP MA plans with more than 80 percent enrollment by both full- and partial-benefit dually eligible individuals to continue to operate. These include nine D–SNP look-alikes in states that have D–SNPs or MMPs that only enroll full-benefit dual eligible individuals. Those nine plans would continue to operate if, as suggested by a commenter, we did not count partial-benefit dually eligible individuals towards the threshold only in states that exclude these individuals from D–SNPs and other integrated plans. While partial-benefit dually eligible individuals are not currently eligible to enroll in D–SNPs or MMPs in those states, they have access to other MA plans that are not D–SNP look-alikes. As discussed in the proposed rule, over 98 percent of dually eligible individuals who are enrolled in non-SNP MA plans are in plans that are not D–SNP look-alikes.

The data show that the exclusion of partial-benefit dually eligible individuals would render the proposed regulation ineffective in achieving its primary goal: Preserving the ability of CMS and states to meaningfully implement the BBA of 2018 requirements and to use D–SNPs and other integrated care plans to integrate Medicare and Medicaid for dually eligible individuals.

In addition, exclusion of partial-benefit dually eligible individuals from the threshold would allow any MA organization to design a benefit package and target enrollment for an MA plan that exclusively enrolled partial-benefit dually eligible individuals. Section 1859(b)(6)(B)(ii) of the Act, however, only allows D–SNPs to exclusively enroll dually eligible individuals.

Comment: Some commenters recommended excluding partial-benefit dually eligible individuals from the threshold and put forward a number of rationales for their recommendation. Some commenters stated that partial-benefit dually eligible individuals did not benefit from the coordination of Medicaid benefits provided by D–SNPs or other integrated plans because they were not entitled to receive such benefits. A few commenters also noted that many states exclude partial-benefit dually eligible individuals from D–SNPs or other integrated plans, and therefore excluding partial-benefit dually eligible individuals from the enrollment threshold would ensure the availability of another meaningful plan option to such individuals. A few commenters noted that partial-benefit dually eligible individuals have greater social, functional, and health needs than the broader Medicare population and could benefit from the enhanced care coordination provided by MA plans, including the D–SNP look-alike in which they enrolled. Another commenter requested that CMS provide an analysis of how the proposed regulation would impact areas where partial-benefit dually eligible individuals are not allowed to enroll in D–SNPs or other integrated care options. A commenter that supported inclusion of partial-benefit dually eligible individuals in the 80 percent threshold stated that any CMS decision to exclude such individuals should be accompanied by a reduction in the threshold to capture roughly the same number of D–SNP look-alikes.

Response: We do not find these commenters' arguments persuasive. First, partial-benefit dually eligible individuals benefit from the requirements that SNPs, including D–SNPs, have a MOC that addresses enrollees' needs and perform periodic HRAs precisely because these

individuals have greater social, functional, and health needs. States, through their contracts with D–SNPs, can enhance these care coordination requirements, including for partial-benefit dually eligible individuals. Second, QMBs without full Medicaid benefits, who constitute roughly half of partial-benefit dually eligible individuals nationally, can benefit when D–SNPs, or the Medicaid managed care plans offered under the same parent company in which these individuals are enrolled, pay providers for Medicare cost sharing under a capitation agreement with the state. Such direct and seamless payment of cost sharing can result in an improved experience for providers serving these individuals, which itself may improve access to care for beneficiaries.

Of course, partial-benefit dually eligible individuals cannot benefit from these features of the D–SNP program if the state D–SNP contract excludes these individuals from enrollment, and we recognize that some states using managed care as a platform for integration exclude partial-benefit dually eligible individuals from D–SNPs and other managed care plans. While some states that are using the D–SNP platform for integration only allow full-benefit dually eligible individuals to enroll in D–SNPs, others allow partial-benefit dually eligible individuals to enroll in separate D–SNP plan benefit packages, facilitating integrated care and seamless provision of benefits for both categories of dually eligible individuals. We think that allowing D–SNP look-alikes to continue to enroll partial-benefit dually eligible individuals with no limit would discourage states from taking this approach.

Comment: A number of commenters recommended that we set a lower threshold for the percentage of dually eligible enrollees a non-SNP MA plan could have, either in actual or projected enrollment. These commenters expressed concern that a threshold of 80 percent could be ''gamed'' by MA organizations to keep their dual eligible enrollment just under the ceiling. Some commenters recommended that CMS set the ceiling for dual eligible enrollment at 50 percent, with a commenter citing MACPAC analysis showing faster growth in projected enrollment among MA plans with dual eligible enrollment greater than 50 percent than among those greater than 80 percent. Another commenter recommended a threshold of 60 percent.

Response: We appreciate the concern that CMS establish a threshold that is effective at curtailing D–SNP look-alikes, which we believe threaten to undermine our ability and that of our state partners to implement the higher integration standards under the BBA of 2018. However, as described in the proposed rule, we believe our proposed 80 percent threshold is reasonable because it far exceeds the share of dually eligible individuals in any given market—no market has more than 50 percent dually eligible beneficiaries [15]—and, therefore, would not be the result for any plan that had not intended to achieve high dually eligible enrollment. The 80 percent threshold also captures almost three-quarters of enrollment in non-SNP plans with more than 50 percent dually eligible enrollees. We will monitor for potential gaming after implementation of this final rule by reviewing plan enrollment data, including the Monthly Membership Report, and consider future rulemaking as needed.

Comment: A range of commenters, including MACPAC and MedPAC, supported the proposed 80 percent threshold for projected and actual enrollment. Along with several other commenters, MACPAC and MedPAC urged CMS to monitor levels of MA dual eligible enrollment after implementation to verify that the final rule's requirements remain effective against the proliferation of D–SNP look-alikes.

Response: We thank the commenters for their support and agree that post-implementation monitoring will be important to determine the effectiveness of the rule. We are finalizing the proposed regulatory language regarding the dual eligible enrollment threshold at paragraphs (d)(1)(ii) and (d)(2)(ii) of this final rule and reiterating here that the threshold includes enrollment of all categories of dually eligible individuals, including partial-benefit and full-benefit dually eligible individuals who are actually enrolled in medical assistance under a state plan under Title XIX.

Comment: A commenter requested that we clarify that the 80 percent threshold applies at the plan level (that is, the PBP level) and not at the contract, or ''H number,'' level.

Response: We reiterate here that the 80 percent threshold in paragraphs (d)(1)(ii) and (d)(2)(ii) applies at the plan level and not at the contract, or ''H number,'' level.

Comment: A commenter requested that we specify the data source used to determine the percentage of dually eligible enrollees in a plan subject to the proposed regulation.

Response: We intend to use data and reports on January enrollment and dual eligible status, such as the January Monthly Membership Report, generated by the MARx system (or a similar or successor report) to determine the percentage of dually eligible enrollees.

Comment: Several commenters stated that our proposed regulatory language at § 422.514(d), ''CMS does not enter into or renew a contract under this subpart for an MA plan,'' was confusing since the language references both contracts and plans. These commenters suggested that CMS clarify that it will not approve or renew a specific plan benefit package (PBP), rather than the entire contract, when D–SNP look-alike MA plans meet the 80 percent threshold.

Response: We appreciate the commenters' request for clarification. When an MA organization enters into a contract with CMS to offer MA products, the MA organization can establish multiple PBPs within that one contract, so long as those products are the same type (for example, all HMO or all PPO). We proposed the language at paragraph (d) to accommodate this reality. When an MA organization has multiple plans under one contract, § 422.514(d), read in combination with contract severability rules at § 422.503(e), allows CMS to sever the D–SNP look-alike from the rest of the contract, in effect allowing CMS to renew only the portion of the contract that does not include the D–SNP look-alike. We believe the language at paragraph (d) accurately describes our intent. Therefore, we are finalizing this regulatory language as proposed. In addition, for those circumstances where the D–SNP look-alike is the only PBP offered in the contract, we are finalizing a new paragraph (f) to clarify that we would consider actions taken consistent with paragraph (d) to warrant special consideration to exempt affected MA organizations from the denial of an application for a new contract or service area expansion pursuant to §§ 422.502(b)(3) and (4), 422.503(b)(6) and (7), 422.506(a)(3) and (4), 422.508(c) and (d), and 422.512(e)(1) and (2). In other words, when CMS declines to enter into or renew a contract consistent with paragraph (d), that action does not preclude the impacted MA organizations from applying for a new MA contract or a service area expansion or its board members or trustees from serving another MA organization.

Comment: A commenter recommended that CMS consider defining D–SNP look-alikes as MA organizations that offer a D–SNP and an MA–PD plan under the same contract, with the majority (that is, 50 percent or

[15] *June 2019 MedPAC Report to Congress, Chapter 12* at *http://www.medpac.gov/docs/default-source/reports/jun19_ch12_medpac_reporttocongress_sec.pdf?sfvrsn=0.*

more) of dually eligible beneficiaries enrolled in the MA–PD plan rather than the D–SNP.

Response: While we appreciate the comment, we do not understand the rationale for defining D–SNP look-alikes as MA organizations that have a majority of dually eligible individuals enrolled in an MA–PD plan as compared to a D–SNP offered by the same MA organization. We would be concerned that any such policy would undermine our proposal in two ways. First, it would permit certain organizations to maintain D–SNP look-alikes whenever such plans were coupled with D–SNPs with a larger number of dually eligible individuals, even if the D–SNP is in a different geographic area. Second, it would allow D–SNP look-alikes to continue operating as long as the MA organization did not also offer a D–SNP under the same contract. Therefore, we decline to accept this recommendation.

Comment: A commenter supported CMS' proposal at § 422.514(d)(2) to exempt from the prohibition on D–SNP look-alikes those MA plans that are active for less than one year and with enrollment less than or equal to 200 enrollees at the time of CMS' determination. A few commenters suggested that CMS consider alternative criteria for which new MA plans are exempted from our proposed requirements. A commenter recommended that CMS expand the exemption to plans that had been active three or more years. The commenter believed this change would allow plans to appropriately respond to any unexpected enrollment patterns. Another commenter encouraged CMS to raise the enrollment minimum from 200 enrollees to 500 enrollees to better align with enrollment levels already required for plan viability for Medicare Part D Prescription Drug Plans (PDPs) and reduce administrative burden.

Response: We appreciate the comments, but we do not find the recommended changes to be persuasive. While the minimum enrollment threshold for low enrollment PDPs is higher at 1,000 beneficiaries, we do not believe PDPs are an apt comparison. We believe a better comparison for D–SNP look-alikes is the minimum enrollment threshold for low enrollment SNPs, which is 100 enrollees for plans in existence for three or more years, as outlined in the 2020 Final Call Letter.[16] We proposed a minimum enrollment standard of 200 to allow some additional flexibility for initial enrollment patterns that may not be representative of the longer term enrollment pattern for the plan. Once the initial enrollment period has passed or the number of enrollees during that first year of operation exceeds 200 enrollees, we believe the enrollment profile accurately reflects whether or not the plan was designed to exclusively enroll dually eligible individuals. Therefore, we are finalizing the D–SNP look-alike exemption criteria in this final rule at paragraph (d)(2)(ii) to exempt those D–SNP look-alikes active for less than one year and with enrollment less than or equal to 200 enrollees at the time of CMS' determination using January enrollment of the current year.

Comment: A commenter noted that certain C–SNPs, including ESRD C–SNPs, may enroll a large number of dually eligible individuals and appreciated that we were clear in the proposed preamble that the proposed enrollment threshold for D–SNP look-alikes only applies to non-SNP MA plans.

Response: We welcome the comment's perspective. As we stated in the proposed rule preamble, we proposed applying this requirement only to non-SNP plans to allow for the predominant dually eligible enrollment that characterizes D–SNPs, I–SNPs, and some C–SNPs by virtue of the populations that the statute expressly permits each type of SNP to exclusively enroll. We are finalizing as proposed at paragraph (d) that the prohibition on D–SNP look-alike contracting does not apply to any specialized MA plan for special needs individuals as defined in § 422.2.

Comment: A commenter supported our proposed implementation timing at paragraphs (d)(1) and (2) to allow D–SNP look-alikes operating in 2020 to transition enrollees to other MA plans offered by the D–SNP look-alikes' parent organizations for an effective date of January 1, 2021, and to no longer enter into or renew contracts with D–SNP look-alikes for plan year 2022 and subsequent years. A few commenters suggested that CMS finalize any policy on D–SNP look-alikes in time for plan year 2021 bid preparation, preferably by April 2020, and to ensure a smooth transition for enrollees. Some commenters requested that CMS delay implementation of the proposed changes by requesting a one-year delay, a two-year delay, or by specifically requesting that D–SNP look-alikes be permitted to operate until 2023 or later. A commenter recommended CMS employ an incremental phased-in approach so that plans above the 80 percent enrollment threshold are permitted to continue operating for a longer period of time. Another commenter suggested that, if CMS will not allow at least an additional year for implementation, CMS allow for continuation of certain plans for the 2022 plan year where the MA organization can demonstrate a good faith effort to apply for and implement a compliant D–SNP product. Commenters cited various reasons for delaying implementation, including allowing MA organizations additional time to file applications, gain approval of compliant D–SNP products, facilitate a smooth transition of enrollees, and consider continuity of care, nuances of state requirements, and market dynamics that might conflict with the proposed rule.

A commenter noted that the need for a delay is particularly important in states where plans' ability to create D–SNPs is limited, and several commenters emphasized the need for sufficient time to develop new products, especially to meet state requirements for integrated plans. A few commenters indicated that CMS' proposed timeline did not align with the California Advancing and Innovating Medi-Cal (CalAIM) initiative to integrate Medicare and Medicaid through D–SNPs and Medicaid MLTSS plans. These commenters expressed concern that, under the proposed timeline, D–SNP look-alike enrollees in California could face multiple Medicare plan transitions in a short period of time, which would potentially disrupt care and confuse beneficiaries. These commenters believed that a later implementation timeframe would allow D–SNP look-alikes extra time to implement a transparent process by which beneficiaries can select plans and transition with minimal disruption.

A commenter noted the additional time necessary for approval of new D–SNPs and a coordinated transition process is especially important given the COVID–19 pandemic. Another commenter requested that CMS allow at least two years for dually eligible individuals, MA plans, states, and other stakeholders to review policy options and devise and implement viable alternatives to CMS' proposal to achieve compliance.

Response: We appreciate the comments supporting the proposed implementation timeline, and we agree with many of the comments recommending that we consider delaying the contract limitation for existing D–SNP look-alikes by one year. While we believe the proposed

[16] *https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf.*

implementation timeframe remains feasible, we understand that providing an additional year before CMS declines to renew existing D–SNP look-alike plans would give all states and MA organizations more time to consider and collaborate on a more integrated approach and an appropriate transition for enrollees. However, we disagree with the request to delay the proposed dual eligible enrollment thresholds for at least two years. We believe that delaying our implementation of D–SNP non-renewals for one additional year prior will provide sufficient time for MA organizations to develop and seek approval for new plans, coordinate with state integrated care efforts, and facilitate a transparent and smooth transition of beneficiaries.

Therefore, we are finalizing paragraph (d)(2) to provide that CMS will not renew a contract for a D–SNP look-alike starting for plan year 2023 (rather than plan year 2022 as proposed). For plan year 2023, our determination that plans meet the criteria in paragraph (d)(2) would be based on our assessment of the plan's enrollment in January 2022. This will extend by one year the timeline for CMS to non-renew a contract for any non-SNP plan with actual enrollment consisting of 80 percent or more dually eligible enrollees (with the exception of an MA plan active less than one year and with enrollment of 200 or fewer individuals at the time of the determination). Additionally, we are finalizing paragraph (d)(2) with a slight restructuring of using new paragraphs (d)(2)(i) and (ii) for better organization and clarity.

Comments recommending a delay in implementation were based on MA organizations seeking more time to establish new D–SNPs, ensure smooth beneficiary transitions for existing D–SNP look-alike enrollees, and coordinate transitions with state integrated care approaches. Since these expressed reasons for an implementation delay apply to existing D–SNP look-alikes but not to potential new D–SNP look-alikes that are either in contract application or annual bidding stages, we do not believe there is a need to delay the effective date for the prohibition on CMS not entering into contracts for new D–SNP look-alikes. Implementing the timeline for the prohibition on new D–SNP look-alikes as proposed also avoids the need for additional beneficiary transitions.

We are therefore finalizing our proposal in paragraph (d)(1) that CMS does not enter into a contract—beginning with plan year 2022—for a new MA plan that projects in its bid submitted under § 422.254 that 80 percent or more of its total enrollment are enrollees entitled to medical assistance under a state plan under Title XIX. We are finalizing paragraph (d)(1) with a slight restructuring of using new paragraphs (d)(1)(i) and (ii) for better organization and clarity. We are retaining the proposed date in paragraph (d)(1), despite changing the date in paragraph (d)(2), to prevent the creation of new D–SNP look-alikes in 2022 that CMS would subsequently non-renew one year later. We are also finalizing as proposed the timeline on which MA organizations will be authorized to transition enrollees from a D–SNP look-alike to another plan, proposed at paragraph (e).

The changes to our proposed policy give MA organizations with existing D–SNP look-alikes more time to coordinate with state integrated care approaches and transition enrollees in a thoughtful, transparent manner that minimizes the number of beneficiary transitions. This finalized approach also allows D–SNP look-alikes that are ready to transition their enrollees the ability to do so as soon as 2021 and eliminates the proliferation of new D–SNP look-alikes, beginning in 2022. We are available to provide guidance to any MA organization regarding transition to a new or existing D–SNP and encourage MA organizations to monitor their Monthly Membership Reports to determine if they are approaching or above the allowable threshold for dually eligible enrollees in a non-SNP plan in any state where the contracting limitations under this regulation will apply.

Comment: A commenter noted that if an MA organization has not submitted an application for a D–SNP for contract year 2021, it would not be able to transition D–SNP look-alike enrollees in 2021, as the commenter believed was required under CMS' proposal. This commenter added that some states have not yet clarified which plans will be allowed to offer D–SNPs in specific markets for 2021.

Response: We agree with the commenter that the D–SNPs that will operate in specific markets in plan year 2021 are not yet known and will not be public information until fall 2020. However, we believe this commenter may have misunderstood the timing of our proposal. We proposed to allow, but not require, D–SNP look-alikes operating in 2020 to transition enrollees for an effective date of January 1, 2021, and we proposed that CMS not enter into or renew contracts with D–SNP look-alikes beginning January 1, 2022. As explained earlier in this section, we are finalizing paragraph (d)(2) to allow an additional year—until plan year 2023—before CMS will decline to renew a contract for an existing MA plan that meets our dual eligible enrollment threshold. Under our original proposal, existing D–SNP look-alikes could, but were not required to, transition their enrollees for a January 1, 2021, or a January 1, 2022 effective date before the contract limitation in paragraph (d)(2) requires action by CMS. With our revisions for the final rule, we are also permitting an option for existing D–SNP look-alikes to transition enrollees for a January 1, 2023 effective date. Under the final provisions of § 422.514(d), CMS will permit any new D–SNP look-alike that begins to operate on January 1, 2021 to continue operating until December 31, 2022. However, an MA organization offering such a new D–SNP look-alike could choose to transition its enrollees as early as January 1, 2022. Further, the transition is not required to be only to a D–SNP, so the MA organization operating an existing D–SNP look-alike does not need to apply to offer a D–SNP.

Comment: A number of commenters preferred an alternative discussed in the proposed rule that would require an MA organization to transition any dually eligible individuals enrolled in a non-renewing D–SNP look-alike into a D–SNP for which they were eligible if such a plan is offered by the MA organization. Some of these commenters believed D–SNP look-alikes should not be able to transition dually eligible individuals into other MA plans when a more integrated option exists. A commenter supported this alternative since it viewed a requirement to transition dually eligible individuals into D–SNPs as continuing federal efforts to strengthen integration of care for dually eligible individuals. A commenter specifically suggested that CMS prioritize transition of full-benefit dually eligible individuals to D–SNP products and other integrated plans.

Response: We appreciate the commenters' support for the proposed alternative, and we share the commenters' preference for integrated care. Although we considered an alternative in the proposed rule that would require transitioning any dually eligible individuals into a D–SNP for which they were eligible if such a plan is offered by the MA organization, we opted for proposing a less prescriptive set of transition rules, recognizing a potentially wide array of transition scenarios. We believe that transitioning D–SNP look-alike enrollees to D–SNPs or other plans authorized by CMS to exclusively enroll dually eligible individuals, when one is offered by the

same MA organization or another MA organization that shares the same parent organization as the MA organization, furthers federal goals to integrate care for dually eligible individuals. However, we also expect that some MA organizations may be unable to transition all D–SNP look-alike enrollees into the same MA plan, since the D–SNP look-alike enrollees may not all meet the eligibility criteria for a particular special needs plan offered by the MA organization or another MA organization that shares the same parent organization as the MA organization.

Our proposal included language at paragraph (e)(1) to allow MA organizations to transition D–SNP look-alike enrollees into one or more MA plans that meet the criteria proposed at paragraphs (e)(1)(i)–(iii). While we expect and encourage dually eligible enrollee transitions to D–SNPs or other integrated plans to occur in many cases, even in the absence of a specific federal requirement, we believe that the complexities associated with a regulation that prioritizes or restricts transitions to D–SNPs or other integrated plans that way would outweigh the potential benefits. Thus, we are finalizing paragraph (e) that an MA organization with a non-SNP MA plan determined to meet the enrollment threshold finalized at paragraph (d)(2)(ii) may transition enrollees into another MA–PD plan (or plans), including a D–SNP, if offered by the same MA organization, as long as any such MA–PD plan meets certain proposed criteria finalized at paragraph (e) and, if such transition is to a D–SNP, enrollees meet the D–SNP eligibility criteria.

Paragraph (e) allows MA organizations multiple options. First, an MA organization can choose not to participate in any transition process under paragraph (e), in which case the enrollees in a D–SNP look-alike would be enrolled by default in the original Medicare fee-for-service program, unless the enrollee made an active choice otherwise. Second, an MA organization can choose to transition all enrollees from a D–SNP look-alike to a different plan that meets the criteria in paragraph (e)(1). Third, recognizing that D–SNP look-alike enrollees may not all qualify for the same new plan, paragraph (e) allows an MA organization to transition look-alike enrollees to multiple plans. For example, an MA organization could transition from its D–SNP look-alike: (1) Dually eligible enrollees into a D–SNP for which they were eligible and (2) non-dually eligible enrollees into a non-SNP plan, provided both plans meet the criteria in paragraph (e)(1).

MA organizations must abide by the anti-discrimination provision (based on health status) in section 1852 of the Act and § 422.110 and other applicable law (for example, civil rights law) when exercising the transition authority. These provisions are applicable to the enrollment transitions authorized under § 422.514(e) and would be especially important to consider where an MA organization chooses to transition enrollees into more than one MA plan. With the exception of transitioning an individual into a C–SNP, an MA organization must not choose a particular plan for an enrollee to transition into based on health status, if the enrollee were eligible for more than one plan offered by the MA organization or its parent organization to receive transitioned enrollees. For example, it would be a violation of the anti-discrimination provision if an MA organization transitioned most dually eligible members from a D–SNP look-alike to a D–SNP but transitioned dually eligible members with diabetes to a different qualifying non-SNP MA plan. As necessary, we will monitor use of the transition authority under this rule to ensure compliance with the applicable anti-discrimination provisions and may take other action as warranted to protect beneficiaries.

Finally, we note that we intend to inform state Medicaid agencies of transitions of enrollees from D–SNP look-alikes into D–SNPs in their state so the states are aware for purposes of their own integrated care efforts and communications with stakeholders.

Comment: A commenter requested that CMS add language that specifically includes MMPs as a plan type eligible to receive beneficiaries who transition from D–SNP look-alikes. Another commenter requested that states be given the flexibility to transition dually eligible look-alike enrollees into a D–SNP or other plan authorized by CMS to exclusively enroll dually eligible individuals, such as an MMP.

Response: We appreciate these comments. The proposed language did not explicitly name MMPs as a type of MA plan into which D–SNP look-alike enrollees could transition because MMPs are not defined in regulation, and CMS can facilitate enrollments from D–SNP look-alikes into MMPs under separate authority. We clarify that MMPs are a type of plan authorized to exclusively enroll individuals entitled to medical assistance under a state plan under Title XIX. CMS is testing the Financial Alignment Initiative under section 1115A of the Act. Some of the demonstration states in the Financial Alignment Initiative are transitioning individuals from an MA plan, including a D–SNP look-alike, to an MMP through passive enrollment. If an MA organization also sponsors an MMP and desires to transition D–SNP look-alike enrollees to the MMP, we would partner with the state Medicaid agency and use our existing authority and processes to execute the transition. Outside of the context of a demonstration or model test under section 1115A of the Act, however, we do not agree with the commenter's request that states be given the flexibility to transition D–SNP look-alike enrollees. CMS will work directly with D–SNP look-alikes to operationalize the transitions, consistent with other Medicare plan transitions, and ensure states are aware of them.

Comment: A commenter requested that CMS ensure dually eligible individuals who previously received care through a managed care plan do not default into the original Medicare fee-for-service program. The commenter stated that these individuals should have the opportunity and support necessary to choose a plan that meets their needs and does not disrupt their care.

Response: We appreciate the commenter's request and agree with the concern. However, we expect the number of D–SNP look-alike enrollees who enroll in the original Medicare fee-for-service program as a result of this rulemaking to be very small. In our proposed Collection of Information (COI) burden estimates, we estimated that only one percent, or 1,808, D–SNP look-alike enrollees would make a Medicare choice other than the MA plan into which they are transitioned by the MA organization. Our estimate was based on our experience with the rate of dually eligible enrollees opting-out of passive enrollment from an MA plan to an MMP offered by the same parent organization as part of the Medicare-Medicaid Financial Alignment Initiative.

Comment: A commenter requested that CMS clarify whether the proposed transition approach allows transition of D–SNP look-alike enrollees to MA plans of a different plan type, such as from an HMO to a PPO.

Response: We appreciate the commenter's request for clarification. In the proposed rule, we stated that our proposed transition process was conceptually similar to ''crosswalk exception'' procedures historically allowed by CMS and proposed at § 422.530 in the proposed rule. We also clarified that, in contrast to the proposed crosswalk exceptions, our proposal would allow the transition process to apply across legal entities

offered by MA organizations under the same parent organization, as well as between SNPs and non-SNP plans. However, it was not our intent to allow for the transition process to apply across product types—for example, HMO to PPO, and vice versa. We are therefore modifying the regulation text to add a new paragraph (e)(1)(iv) to stipulate that an MA plan or plans receiving enrollees under the transition process we are finalizing in paragraph (e) must be of the same plan type (for example, HMO or PPO) as the D–SNP look-alike. An MA organization will not be permitted to transition an individual from a D–SNP look-alike PPO to an MA–PD plan that is an HMO, or vice versa.

Comment: A commenter appreciated that our proposed transition gives D–SNP look-alikes the ability to transition non-D–SNP members into a D–SNP across legal entities. This commenter requested that CMS allow transitions across legal entities in other situations where it would be in the beneficiary's best interest, such as transitioning a beneficiary with a chronic condition into a C–SNP under a different legal entity.

Response: The commenter's understanding of our proposed transition approach in § 422.514 in connection with transitioning enrollees out of a D–SNP look-alike is accurate. Our approach, which we are finalizing as proposed at paragraph (e), allows MA organizations to transition D–SNP look-alike enrollees into an MA plan or plans which meet the criteria in paragraph (e)(1) and are offered by the same MA organization or another MA organization that shares the same parent organization as the MA organization. Under our approach, D–SNP look-alike enrollees who are eligible for a C–SNP could be transitioned into a C–SNP that meets the criteria in paragraph (e)(1). With regard to crosswalks or enrollment changes in other contexts, the recommendation is outside of the scope of our proposal for § 422.514; we will take the comment under consideration in connection with the crosswalk proposal (proposed to be codified at § 422.530) in section VI.C. of the proposed rule, which we intend to address in a future final rule.

Comment: Some commenters encouraged CMS to finalize the proposed policy on D–SNP look-alikes with sufficient advance timing, preferably in advance of the 2021 bid deadline, to allow for enrollee transitions.

Response: We agree it is important, where possible, to finalize the policy in advance of bid deadlines so that MA organizations can have sufficient time to make decisions for 2021 plan offerings. At paragraph (d), we are finalizing the timing of when we would implement the prohibition on contracting for D–SNP look-alikes with the modifications discussed earlier. D–SNP look-alikes operating in 2020 may choose to transition their enrollees effective January 1, 2021, January 1, 2022, or January 1, 2023, and D–SNP look-alikes operating in 2021 may choose to transition their enrollees effective January 1, 2022 or January 1, 2023. For plan year 2022 and subsequent years, CMS will not enter into a contract with a new MA plan that meets criteria outlined in paragraph (d)(1), and for plan year 2023 and subsequent years, CMS will not renew a contract with a MA plan that meets criteria outlined in paragraph (d)(2). We note that MA organizations will be able, under § 422.514(e) as finalized here, to transition enrollees in D–SNP look-alikes to other plans in advance of CMS non-renewing the D–SNP look-alike PBPs effective January 1, 2023 and January 1 of subsequent plan years.

Comment: A commenter noted that D–SNPs currently must have executed state Medicaid agency contracts with applicable states and requested that CMS also allow plans to meet this requirement with subcontracts through a directly contracted entity in order to ease transitions for beneficiaries into the most integrated plan possible.

Response: Consistent with the revised SMAC requirements and the new definition of a D–SNP codified in the April 2019 final rule, a plan must have a direct contract with the state Medicaid agency to meet the definition of a D–SNP at § 422.2. CMS does not consider subcontracting arrangements with Medicaid managed care plans in lieu of SMACs to approve a plan as a D–SNP.

Comment: A commenter recommended that CMS allow an opt-out process for D–SNP look-alike enrollees being transitioned to a new plan. The commenter indicated that such an opt-out process would preserve beneficiary choice.

Response: We appreciate the comment and agree that the ability of an enrollee to opt out is important to ensure beneficiary choice. As we discussed in the preamble of the proposed rule, an MA organization with a non-SNP MA plan determined to meet the enrollment threshold in proposed paragraph (d)(2) could transition enrollees into another MA–PD plan (or plans) offered by the same MA organization, as long as any such MA–PD plan meets certain criteria described in the proposed rule and finalized here. Under the transition authority we are finalizing, an MA enrollee could be transitioned from one MA plan offered by an MA organization to another MA–PD plan (or plans) without the enrollee having completed an election form or otherwise indicate their enrollment choice as typically required. However, the timing of these transitions permits the enrollee to make an affirmative choice for another MA plan of his or her choosing during the annual election period (AEP) from October 15 through December 7. Section 422.514(e) ensures this right because the description of the MA plan to which the enrollee would be transitioned must be provided in the ANOC that must be sent consistent with requirements in § 422.111(a), (d), and (e). The ANOC must be sent at least 15 days before the beginning of the AEP. Enrollees would still have the opportunity to choose their own plan during this transition process because of how the proposed transition process would overlap with the annual coordinated election period. If a transitioned enrollee elects to enroll in a different plan during the AEP, enrollment in the plan the enrollee selected would take precedence over the plan into which the MA organization transitioned the enrollee. Transitioned enrollees would also have additional opportunities to select another plan through the Medicare Advantage Open Enrollment Period described in § 422.62(a)(3) from January 1 through March 31. Affected individuals may also qualify for a Special Election Period (SEP), such as the SEP for plan non-renewals at § 422.62(b) or the SEP for dually eligible individuals or Part D low-income subsidy eligible beneficiaries at § 423.38(c)(4). For D–SNP look-alike enrollees who are not transitioned by an MA organization per proposed paragraph (e)(1), the MA organization must send a written notice consistent with § 422.506(a)(2). This requirement will ensure that the content of that notice includes the content sent when a plan is non-renewing (including information about other enrollment options) and that the notice is sent by October 2 (90 days before the end of the year). We believe that the transition process we proposed and are finalizing provides sufficient opportunity for affected enrollees to opt out of their new plan and make a different election. Therefore, as described earlier in this section, we are finalizing the transition process at paragraph (e) largely as proposed with some minor modifications and technical changes described elsewhere in this section.

Comment: A few commenters expressed concern about the disruption

of aligned Medicare and Medicaid coverage at the point of transition, especially when an individual is enrolled in a Medicaid plan under the same parent organization as the D–SNP look-alike. These commenters recommended that affected beneficiaries be permitted to stay with the MA plan or MA organization to ensure continued integration of Medicare and Medicaid benefits. The commenters believed that such a disruption in ongoing care plans and care teams at the individual level would likely outweigh any additional benefit from the D–SNP integration requirements at the plan level.

Response: We appreciate the commenters' concerns about potential disruption of aligned coverage. The transition approach proposed and finalized at paragraph (e) permits MA organizations to transition D–SNP look-alike enrollees into another MA plan or plans (including into a D–SNP for enrollees who are eligible for such a plan) offered by that MA organization or by another MA organization that shares the same parent organization. We expect the vast majority of D–SNP look-alike enrollees to be transitioned into a plan offered by the same parent organization as the D–SNP look-alike, which would facilitate the sharing of any enrollee care plans and, in some cases, continued access to the same care teams. Also, as explained earlier in this section, we estimate that only one percent of D–SNP look-alike enrollees will move to the original Medicare fee-for-service program or to another MA plan outside of the same parent organization. To the extent that any enrollees in a D–SNP look-alike are enrolled in a Medicaid managed care plan under the same parent organization as the D–SNP look-alike, the transition authority finalized in paragraph (e) allows similar enrollment in plans offered by the same entity or parent organization.

Comment: Some commenters requested that CMS consider state-specific integrated care initiatives as it finalizes its transition policy. In particular, a few commenters encouraged CMS to coordinate transition of D–SNP look-alikes with states where integrated care plan initiatives are proposed or underway to avoid unintended confusion or enrollment barriers for dually eligible individuals. A commenter suggested that CMS issue guidance to states about enrollee transitions initiated by D–SNP look-alikes so that transitions of dually eligible individuals are coordinated with any changes that states are proposing in Medicaid enrollment, which would help minimize the number of transitions an individual experiences over a short period of time. A few commenters requested that CMS consider the impacts of any state-imposed moratorium on contracting with D–SNPs in counties where MMPs are offered, citing such a policy in California. A commenter stated that any such moratorium could affect the ability of individuals who have opted out of MMPs or do not meet MMP eligibility criteria to enroll in other integrated plan options. Another commenter noted that D–SNPs are best positioned to meet the unique needs of dually eligible individuals, and the California restrictions on D–SNP enrollment are harmful when dually eligible individuals do not have the flexibility to enroll in a D–SNP. This commenter expressed concern that if CMS moved forward with the proposed policy and D–SNPs remained closed to enrollment, beneficiaries in areas like those in certain California counties would likely enroll in non-SNP MA plans that not only would not offer the care coordination required by D–SNPs, but may impose higher premiums and out-of-pocket expenses.

Response: We thank the commenters for sharing these concerns. As we stated in our proposed rule preamble, section 164(c)(4) of MIPPA does not obligate states to contract with D–SNPs, which therefore provides states with significant control over the availability of D–SNPs. As discussed earlier, we are finalizing language to delay CMS non-renewal of D–SNP look-alikes to January 1, 2023 and subsequent years, to allow more time for MA organizations and states to coordinate transitions. This delay will also better align the timing of any enrollee transitions from D–SNP look-alikes in California with the current CalAIM implementation timing of January 1, 2023. We do not expect D–SNP look-alike enrollees to experience higher premiums since the transition approach proposed and finalized at paragraph (e) only permits MA organizations to transition D–SNP look-alike enrollees into MA plans that meet certain criteria, including having a combined Part C and Part D premium of $0 for individuals eligible for the premium subsidy for full subsidy eligible individuals described in § 423.780(a).

Comment: A commenter appreciated CMS giving MA plans the ability to transition enrollees in non-D–SNP look-alikes into D–SNPs across legal entities but expressed concern that there could be disproportionate and unintended impacts to the Members Choosing to Leave the Plan Star Rating measure for contracts with the D–SNP look-alikes where the transition authority is used. This commenter requested that CMS ensure that all proposed D–SNP look-alike transitions are excluded from the Members Choosing to Leave the Plan Star Rating measure because the commenter did not believe this measure, which is representative of enrollee satisfaction, would accurately reflect performance if transitioned members were included in the measure.

Response: We thank the commenter for raising this issue. The specifications for the Members Choosing to Leave the Plan Star Rating measure allow beneficiaries transitioned as a result of a PBP termination to be excluded from the calculation of this Star Rating measure. The vast majority of D–SNP look-alike enrollees transitioned into another MA plan or plans will be identified in MARx as disenrollment reason code 09, termination of a contract (CMS-initiated), or disenrollment reason code 72, disenrollment due to a plan-submitted rollover. Neither disenrollment reason code 72 nor 09 will be counted toward the calculation of the Members Choosing to Leave the Plan Star Rating measure. As discussed earlier, we estimated one percent of, or 1,808, D–SNP look-alike enrollees would make a Medicare choice other than the MA plan into which they are transitioned. MARx will identify these transitions as disenrollment code 13, disenrollment because of enrollment in another plan, and these transactions will be counted toward calculation of the Members Choosing to Leave the Plan Star Rating measure. Since such a small number of transitioning D–SNP look-alike enrollees would be counted, we do not believe a change to the Star Rating measure specifications is needed.

Comment: Some commenters requested that CMS only permit D–SNP look-alikes to transition members into other MA plans for which provider networks have at least a 90 percent overlap with the provider network of the D–SNP look-alike. These commenters requested that, if this standard is not met, enrollees should not be transitioned to another plan and instead default to coverage under the original Medicare fee-for-service program. One of these commenters noted that because any plan receiving D–SNP look-alike enrollees would be part of the same parent organization as the D–SNP look-alike, that parent organization could adjust the MA plan networks to meet this 90 percent standard.

Response: We appreciate the commenters' concern that dually eligible individuals maintain their providers from the network of the D–

SNP look-alike. As we discussed in response to other comments, MA organizations may transition enrollees from a D–SNP look-alike into another MA plan offered by the same parent organization, including a D–SNP. Many provider participation agreements used by MA organizations include provisions that the providers contract for all product types the MA organization offers. In fact, CMS assesses network adequacy at the contract level rather than at the plan level (see section V.A. of this preamble). In similar instances where CMS transitioned enrollees from MMPs to D–SNPs under the same parent organization, there was a high degree of overlap in the provider network, as assessed at the contract level. Based on our understanding of common contracting processes and past experience with MMPs and MA organizations that offer D–SNPs, we believe a high degree of overlap will exist between the contracted provider networks in a D–SNP look-alike and a MA plan offered by the same parent organization, making it unnecessary for CMS to impose a standard that requires a specific percentage of provider overlap. Additionally, and as we noted earlier in this section, in those instances where a dually eligible individual receives notice that they are being transitioned to a MA plan that does not include their providers, they retain the ability to choose a different MA plan or the original Medicare fee-for-service program. Finally, in any instances in which there would be meaningful network differences between the D–SNP look-alike and the MA plan to which a member is transitioned, we strongly encourage plans to communicate with members about the potential impacts of such changes.

Comment: A commenter explained that there were many lessons learned during the implementation of Cal MediConnect, a capitated model demonstration under the Financial Alignment Initiative, that highlighted the importance of consumer protections such as continuity of care and network parity. The commenter noted that during the transition to Cal MediConnect, the Department of Health Care Services, California's state Medicaid agency, implemented continuity of care standards and provided guidance allowing the receiving Cal MediConnect plan, which was an MMP, to use the HRA completed by a D–SNP. To minimize disruptions in care, the commenter requested that CMS consider beneficiary protections similar to those included in the state's proposed CalAIM D–SNP transition plan and establish requirements for transferring a D–SNP look-alike enrollee's HRA and care plan, as well as requirements for continuity of care and network parity, and a prohibition on receiving plans' imposition of additional cost-sharing requirements.

Response: We appreciate the commenter's perspective and support a smooth transition between D–SNP look-alikes and another MA plan, but we do not believe establishing additional requirements as suggested is necessary. As discussed in the preamble of our proposed rule, D–SNP look-alikes are not subject to federal D–SNP requirements, including the requirements to develop HRAs and individualized care plans. Thus, we do not expect D–SNP look-alikes necessarily will have any HRAs or care plans to transfer to another MA plan in connection with the transition of a beneficiary's enrollment. As discussed earlier in this section, to the extent that a D–SNP look-alike has developed HRAs or individualized care plans, we expect the vast majority of D–SNP look-alike enrollees to be transitioned into a plan offered by the same parent organization as the D–SNP look-alike. We believe that transitions under paragraph (e) will facilitate the sharing of any HRAs and care plans and promote continuity of care because the new plan will be operated by an entity with the same parent organization, if not the same MA organization, which likely means overlapping or the same personnel and policies. Additionally, all transitioning beneficiaries will have Medicare's standard Part D continuity of care protections for prescription drugs (including temporary fills of non-formulary drugs during a transition period as provided under § 423.120(b)(3)). Plans receiving transitioned enrollees must also provide other continuity of care requirements for MA plans, including those outlined in § 422.112(b). As we describe earlier in this section, we believe that there will be a high degree of provider network overlap across plans that are offered by the same MA organization or share a parent organization, making it unnecessary for CMS to impose a standard that requires a specific percentage of provider overlap. Finally, we do not expect D–SNP look-alike enrollees to experience higher premiums since the transition approach proposed and finalized at paragraph (e) only permits MA organizations to transition enrollees in a D–SNP look-alike into MA plans that meet certain criteria, including having a combined Part C and Part D premium of $0 for individuals eligible for the premium subsidy for full subsidy eligible individuals described in § 423.780(a). We also note that, pursuant to § 422.504(g)(1), MA organizations cannot impose cost sharing requirements for Medicare Parts A and B services on full-benefit dually eligible individuals that would exceed the amounts permitted under the state Medicaid plan if the individual were not enrolled in the MA plan.

Comment: Several commenters encouraged CMS to require that the ANOC notifying a beneficiary being transitioned to a new plan identify D–SNP look-alike providers known to not be in the receiving plan's network, focusing specifically on primary care providers and specialists who the beneficiary has seen twice or more in the past year. One of these commenters explained that this information would help beneficiaries make informed choice about whether to participate in the transition and prevent surprise access-to-care issues in the early months of enrollment. A commenter expressed a similar view but suggested the ANOC identify any providers seen in last year. Another commenter noted the importance of a plan's provider network to beneficiaries with disabilities. We also received one comment recommending that the ANOC contain information about other plan options.

Response: We appreciate the commenters' perspectives and support transparency on MA provider networks, but we do not agree that the ANOC is an appropriate means of communicating beneficiary-specific provider information since it is not a beneficiary-specific notice. Standardized language in the ANOC model already provides general information about changes to an MA plan's network and directs enrollees to the plan's updated provider network directory to help with decision-making during the AEP. As we discussed earlier in this section, we believe the vast majority of D–SNP look-alike enrollees will be transitioned into an MA plan within the same parent organization as the D–SNP look-alike and there will be a high degree of provider network overlap across plans that are offered by the same MA organization or share a parent organization, lessening the need to provide beneficiary-specific provider information. Additionally, and as we noted earlier in this section, in those instances where a dually eligible individual is transitioned to a MA plan that does not include their providers, they retain the ability to choose a different MA plan or the original Medicare fee-for-service program.

While we support beneficiary education and choice about plan options, we also do not believe the ANOC is the appropriate vehicle for communicating information about other plan options. As described earlier, the transition process of D–SNP look-alike enrollees into another MA plan or plans will overlap with the AEP. Enrollees who are subject to being transitioned under § 422.514(d) have multiple ways of identifying other plan choices, such as through reviewing the Medicare & You Handbook, consulting Medicare Plan Finder, and contacting 1–800-Medicare and the State Health Insurance Assistance Program in their state.

Comment: A commenter requested that CMS provide guidance for providers and beneficiaries explaining why the transition from D–SNP look-alikes to another MA plan or plans is occurring.

Response: We appreciate the comment and the desire for providers and beneficiaries to be informed about the transition. However, we believe it is the responsibility of MA organizations that are transitioning enrollees to other MA plans to educate providers and enrollees about the transition and the benefits of the new (receiving) plans. As discussed earlier in this section, the MA organization receiving D–SNP look-alike enrollees is required to send these enrollees an ANOC consistent with § 422.111(a), (d), and (e) that includes information on benefits and provider network changes. We are, however, finalizing paragraph (e)(2)(ii) with minor modifications to clarify that the responsibility of providing information to transitioned enrollees in the ANOC rests with the MA–PD plan into which individuals are transitioned, and that the ANOC describes changes to the MA–PD plan's benefits and provides information about the MA–PD plan.

Comment: A commenter expressed support for the proposed D–SNP look-alike contracting standards, while noting potential negative impacts, including reduced plan competition and consumer choice. The commenter recommended that states be required to contract with all MA–PD plans that have an approved MOC and suggested three different contracting options: (1) States enter into a care coordination contract with plans; (2) states pay plans to coordinate Medicare and Medicaid services, assuring alignment with the state's strategy to deliver LTSS or managed LTSS (MLTSS); and (3) states pay plans to coordinate Medicare and Medicaid services and deliver LTSS. Another commenter suggested that plans meeting certain CMS criteria for integrated care could earn a ''Standard of Excellence for Dually-Eligible Individuals'' seal of approval that could be used for marketing purposes and posting on Medicare Plan Finder.

Response: We appreciate the commenters' input on strategies that could improve plan competition and support consumer choice. We note that some of the commenters' recommendations, such as requiring states to contract with all MA–PD plans that have an approved MOC, are beyond CMS's existing authority. As we gain experience with implementing the requirements in this final rule, we will take into consideration those recommendations that are within CMS's authority.

Comment: A commenter recommended CMS consider requiring that any entity that meets the 80 percent dual enrollment threshold meet minimum standards of integrated care coordination and data sharing for its full-benefit dually eligible members, including in the eight states that do not currently have any D–SNPs (as of July 2019). This commenter supported requiring that MA organizations in these eight states transition members to an MMP if one exists or, if one does not, submit a MOC, complete HRAs, and provide integrated care coordination and information sharing for all of its full-benefit dually eligible members.

Response: We appreciate the commenter's alternative approach. We clarify that proposed paragraphs (d)(1) and (2) would, in fact, limit new and existing D–SNP look-alikes from operating in states where a D–SNP or any other plan authorized by CMS to exclusively enroll individuals entitled to medical assistance under a state plan under Title XIX, including MMPs, exists. The limit on new D–SNP look-alikes precludes CMS from entering into a new contract for a D–SNP look-alike for 2022 and subsequent years. The limit on existing D–SNP look-alikes precludes CMS from renewing a contract for an existing D–SNP look-alike for 2023 and subsequent years. However, under current law, CMS does not have the authority to require D–SNP look-alikes in the eight states without D–SNPs to submit MOCs, conduct HRAs, or provide integrated care coordination and information for all of its full-benefit dually eligible members. Section 1859(f) of the Act requires that each D–SNP have a contract with the state Medicaid agency; this requirement is in addition to other D–SNP requirements this commenter references. Allowing D–SNP look-alikes to operate without such state contracts would allow such plans to circumvent an important D–SNP requirement.

Comment: A few commenters proposed the application of new federal measures nationwide that would require D–SNP look-alikes to make progress on a pathway toward greater care integration. Rather than not approving or renewing contracts for certain D–SNP look-alikes, a commenter suggested that this alternative approach would assure continued beneficiary choice, as certain integrated care plans receive lower Star Ratings than other plans that do not provide integrated care. Another commenter suggested that D–SNP look-alikes could provide more integrated care if CMS required them to notify the state Medicaid agency or appropriate Medicaid managed care plan when full-benefit dually eligible individuals are admitted to a hospital or skilled nursing facility (that is, the requirement recently codified at § 422.107(d) as one of three integration options available to D–SNPs beginning in 2021).

Response: We appreciate the support for increased opportunities to integrate care for individuals who are dually eligible and the importance of beneficiary choice. Though we intend, through this final rule, to discourage the rapid proliferation of D–SNP look-alikes that undermine the statutory and regulatory framework for D–SNPs, we will continue to consider other ways to further promote integrated care for individuals who are dually eligible.

Comment: A few commenters proposed that CMS conduct additional research on the market dynamics of D–SNP look-alikes, noting factors such as incentives for brokers who steer enrollees toward or away from certain service delivery models. These commenters suggested that, rather than implementing broad restrictions on D–SNP look-alikes, CMS could address those market distortions directly. For example, if D–SNP look-alikes result from inappropriate steering of beneficiaries, these commenters noted that CMS could institute measures reinforcing referrals to products best suited to the beneficiary's needs. A few commenters noted that if misleading marketing practices were found to be a root cause, CMS has regulations and program rules to stop them. Another commenter supported the strong enforcement of existing marketing and broker requirements to prevent the targeting of dually eligible individuals for marketing MA plans that do not offer integrated care. The commenter noted that if CMS believes it lacks the authority required to discontinue this behavior, Congress should grant the agency the authority it needs.

Response: We appreciate the commenters' perspectives on the need

to avoid beneficiary confusion and take steps against misleading marketing practices. Our proposed rule included various proposed provisions codifying previous subregulatory guidance from the Medicare Communications and Marketing Guidelines prohibiting non-D–SNP plans from marketing their plan as if it were a D–SNP; those proposals will be addressed in a future final rule. We note, however, that MA organizations remain responsible for ensuring that their agents and brokers comply with part 422, subpart V. Current requirements (such as § 422.2268(a)(1) and (2)) include prohibitions on misleading or confusing marketing and communications; MA organizations must ensure downstream entities—such as their agents and brokers—that perform marketing or enrollment on behalf of the MA organization also comply with these requirements. We will also continue to monitor plans' compliance with CMS marketing rules prohibiting misleading marketing practices, including activities of agents and brokers, to ensure that dually eligible individuals can make informed choices. This includes review of complaints about inappropriate marketing practices CMS receives through the Complaint Tracking Module described in § 422.504(a)(15). As we gain experience with implementing the requirements in this final rule, we will evaluate whether additional rulemaking on marketing practices is necessary.

Comment: A few commenters suggested improving and increasing education for dually eligible individuals and providers about the benefits of integrated care and the availability of plans that offer such care. A few commenters suggested that brokers should be required to educate dually eligible individuals on the integrated care options within their service area to assure that they can make informed choices. A commenter recommended that CMS require any low-premium MA plan that attracts dually eligible individuals to educate them about the availability of D–SNP options within their service area.

Response: We appreciate recommendations for improved provider and beneficiary education on the availability and benefits of integrated products, and we will take into consideration ways to strengthen agent and broker training requirements and marketing rules within our current authority.

After considering the comments we received and for the reasons outlined in the proposed rule and our responses to comments, we are finalizing our proposed provisions at § 422.514(d) and (e) with the following modifications:

- We are reorganizing the regulation text by adding new paragraphs (d)(1)(i) and (ii) and (d)(2)(i) and (ii) for better organization and clarity of the final requirements, as well as to establish different effective dates for the provisions of paragraphs (d)(1) and (2). Accordingly, we are also updating the reference in paragraph (e)(1)(i) from paragraph (d)(2) to paragraph (d)(2)(ii).
- We are finalizing the provision at paragraph (d)(2) with the date 2023 instead of 2022 to extend by one year the timeline on which the contract limitation will apply to an existing non-SNP plan with actual enrollment consisting of 80 percent or more dually eligible enrollees (with the exception of an MA plan active less than one year and with enrollment of 200 or fewer individuals at the time of the determination).
- We are modifying paragraph (e)(1)(iv) to stipulate that an MA plan (or plans) receiving enrollees under the transition process in paragraph (e) must be of the same plan type (for example, HMO or PPO) as the D–SNP look-alike.
- We are making a minor modification to paragraph (e)(2)(ii) to eliminate the reference to § 422.2267(e)(3), as that proposed provision is not being finalized in this rule. We are also modifying paragraph (e)(2)(ii) to clarify that the responsibility of providing information to transitioned enrollees in the ANOC rests with the MA–PD plan into which individuals are transitioned, and that the ANOC describes changes to the MA–PD plan's benefits and provides information about the MA–PD plan.
- We are finalizing paragraph (e)(4) with a technical change to clarify that the content as well as the mechanism and timing requirements in § 422.506(a)(2) apply to the notice an MA organization must provide to any enrollees in a D–SNP look-alike that the MA organization is not transitioning to a new plan.
- We are adding a new paragraph (f) to clarify that we would consider actions taken consistent with paragraph (d) to warrant special consideration to exempt affected MA organizations from the denial of an application for a new contract or service area expansion pursuant to §§ 422.502(b)(3) and (4), 422.503(b)(6) and (7), 422.506(a)(3) and (4), 422.508(c) and (d), and 422.512(e)(1) and (2).

DISCLAIMER: Based on the tight time constraints and the need to expedite the clearance process to ensure timely publication, OSORA will be simultaneously reviewing this document as part of this clearance process. Specifically, we will be ensuring that the regulation is in compliance with the Office of the Federal Register and the Government Printing Office publication guidelines to include: conforming regulation text, assuring the regulation text and preamble are consistent, the responses to the public comments are responsive, and the document justifies our rationale for finalizing a policy.

III. Implementation of Certain Provisions of the 21st Century Cures Act

A. Medicare Advantage (MA) Plan Options for End-Stage Renal Disease (ESRD) Beneficiaries (§§ 422.50, 422.52, and 422.110)

Section 4001 of the Balanced Budget Act of 1997 (hereinafter referred to as the BBA of 1997) added sections 1851 through 1859 to the Act establishing Part C of the Medicare program known originally as ''Medicare + Choice'' and later as ''Medicare Advantage (MA).'' As enacted, section 1851 of the Act provided that every individual entitled to Medicare Part A and enrolled under Part B, except for individuals with end stage renal disease (ESRD), could elect to receive benefits through an MA plan. The statute further permitted that, in the event that an individual developed ESRD while enrolled in an MA plan or in a health plan offered by the MA organization, he or she could remain in that MA plan or could elect to enroll in another health plan offered by that organization. These requirements were codified at § 422.50(a)(2) in the initial implementing regulations for the Part C program published in 1998 (63 FR 35071).

Section 1851 of the Act was subsequently amended several times to expand coverage of ESRD beneficiaries in MA plans.

- Section 620 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (hereinafter referred to as BIPA), established a one-time opportunity for individuals, medically determined to have ESRD, whose enrollment in an MA plan was terminated or discontinued after December 31, 1998, to enroll in another MA plan.
- Section 231 of the MMA gave the Secretary authority to waive section 1851(a)(3)(B) of the Act, which precludes beneficiaries with ESRD from enrolling in MA plans. Under this authority, CMS undertook rulemaking to allow individuals with ESRD to join an MA special needs plan.

In 2016, paragraph (a) of section 17006 of the Cures Act further amended section 1851 of the Act to remove the prohibition for beneficiaries with ESRD from enrolling in an MA plan. This change is effective for plan years beginning on or after January 1, 2021. (Please see sections III.B. and III.C. of this final rule for further changes established by section 17006 of the Cures Act.) To implement these changes in eligibility for MA plan enrollment made by the Cures Act, we proposed the following amendments:

- Section 422.50(a)(2) would be revised to specify that the prohibition of beneficiaries with ESRD from enrolling in MA plans (and associated exemptions) is only applicable for coverage prior to January 1, 2021.
- Section 422.52(c) would be revised to specify that CMS authority to waive the enrollment prohibition in § 422.50(a)(2) to permit ESRD beneficiaries to enroll in a special needs plan would also only be applicable for plan years prior to 2021.
- Section 422.110(b) would be revised to specify that the exception to the anti-discrimination requirement, which was adopted to account for the prohibition on MA enrollment by beneficiaries who have ESRD, is only applicable for plan years prior to 2021.

As noted earlier, the changes mandated by the Cures Act do not take effect until the 2021 plan year. As such, individuals entitled to Medicare Part A and enrolled under Part B, and medically determined to have ESRD, are not eligible to choose to receive their coverage and benefits through an MA plan prior to plan year 2021, subject to the limited exceptions reflected in the current regulation text.

We received a large number of comments related to this proposal. The discussion below pertains specifically to comments related to eligibility and the removal of the prohibition on beneficiaries with ESRD enrolling in an MA plan as proposed in §§ 422.50(a)(2), 422.52(c), and 422.110(b).

Comment: Generally, all commenters supported the statutory change removing the prohibition for ESRD beneficiaries to enroll in an MA plan. Many commenters noted that allowing these beneficiaries to enroll in MA plans will provide care coordination and, thus, improved clinical outcomes for this vulnerable population. A commenter also noted that MA beneficiaries have a relatively low rate of switching among plans and tend to stay with the selected plan long term, and this could contribute to better outcomes through longer coordination of care. Many commenters stated that this change will provide options for obtaining supplemental benefits and access to health and wellness programs not available in Original Medicare.

Several commenters stated that MA plans provide a maximum out-of-pocket (MOOP) cost sharing for all enrollees, which makes MA an attractive option for these beneficiaries with high annual medical costs. Commenters noted that this MOOP may significantly decrease patients' out-of-pocket costs. A commenter noted that the MOOP is especially important for those ESRD beneficiaries who are under age 65, and may not be eligible to purchase a Medigap policy to supplement their Original Medicare expenses. Several commenters noted that this provision will help improve the lives of, and empower, ESRD beneficiaries consistent with the President's Executive Order on Advancing American Kidney Health.

Response: We agree with the commenters and appreciate their support of the proposal.

Comment: Several commenters requested that CMS clarify if the current optional employer/union group waiver for enrollment of ESRD members will be eliminated and, if so, questioned when guidance would be updated to reflect the change.

Response: Under Section 1857(i) of the Act, CMS has the statutory authority to waive or modify requirements that hinder the design of, the offering of, or the enrollment in, employer/union-sponsored MA plans. As noted in the Medicare Managed Care Manual Chapter 9, section 30.3, CMS used this authority to grant a waiver to allow MA plans offered by MA organizations under contract with an employer or union, or offered directly by an employer or union, to choose to accept enrollees with ESRD under certain circumstances, provided that all otherwise eligible individuals with ESRD are permitted to enroll. With the enactment of the Cures Act, effective plan years on or after January 1, 2021, the prohibition on MA enrollment for ESRD beneficiaries is removed. Therefore, the waiver will no longer be effective and MA plans, including MA EGWPs, must accept enrollments of ESRD beneficiaries. We plan to update guidance as soon as possible.

Comment: A commenter questioned if the 30-month coordination of benefits period for those entitled to Medicare based on ESRD status will be eliminated based on the removal of the prohibition.

Response: The regulation codifies that those individuals with ESRD cannot be restricted from enrolling in an MA plan. However, nothing in the language of the regulation eliminates or is to be construed as eliminating the 30-month coordination of benefits period that section 1862(b)(1) of the Act imposes with regard to Medicare coverage of beneficiaries whose entitlement is based on ESRD. In other words, any Group Health Plan coverage effective at the time a beneficiary with ESRD enrolls in an MA plan will remain the primary payer during the 30-month coordination of benefits period.

Comment: A commenter questioned how removing the prohibition on individuals with ESRD from enrolling in

MA plans will impact the way ESRD information must be obtained and reconciled in order to ensure appropriate payment. The commenter also questioned if CMS is considering increasing resources for the QualityNet helpdesk, as ESRD enrollments in MA plans are likely to increase, which may prompt higher volumes of cases where ESRD statuses and payments need to be reconciled and corrected in the future.

Response: Completion of the CMS–2728–U3 form (*End Stage Renal Disease Medical Disease Evidence Report—Medicare Entitlement and/or Patient Registration,* OMB control number 0938–0046) by a dialysis center, (including physician attestation and patient signature) is required for an individual to be medically determined to have ESRD for purposes of filing for Medicare benefits. However, collection of these data on the CMS–2728–U3 are also used to establish and maintain a nationwide kidney disease registry for dialysis, transplant, and prospective transplant patients, and will store pertinent medical facts on each registrant, regardless of Medicare status. CMS enrollment systems ultimately receive this information resulting in MA plans receiving payment based on ESRD capitation rates and risk adjustment. Further information on this process can be found in section 6.2.2 of the *Plan Communication User Guide for Medicare Advantage Prescription Drug Plans.*

At this time, we have no plans to add additional resources to the QualityNet Help Desk but we will monitor call volumes to see if we need to increase the number of agents fielding ESRD Quality Reporting System calls.

Comment: A commenter requested clarification on whether MA plans will be allowed to include the question regarding ESRD status on the MA enrollment form. The commenter also questioned if this change will impact the required Data Elements to consider an enrollment request complete.

Response: CMS has proposed changes to the standard (''long'') model form used for MA and Prescription Drug Plan (PDP) enrollment (currently approved under OMB control number 0938–0753 CMS–R–267), to reduce data collection and simplify the enrollment process. When adopted, the new, ''shortened'' enrollment form will limit data collection to what is lawfully required to process the enrollment and other limited information that the sponsor is required, or chooses to, provide to the beneficiary. The new ''shortened'' form used for enrollment into MA and PDP plans will not contain the ESRD status question. We expect MA plans to use the new shortened form, (once OMB has approved its use) for the 2020 AEP, which begins on October 15, 2020, for January 1, 2021 effective dates. This timeframe aligns with the effective date of the removal of the prohibition of MA enrollment for ESRD beneficiaries. As the ESRD status question will not be on the form, it is not a data element which will be required to consider the enrollment complete. MA plans do not need to know the ESRD status of an enrollee to process an enrollment in light of the changes made by the Cures Act, and are prohibited from discriminating against potential enrollees on the basis of a health status factor. Data element requirements will be updated in future guidance.

Comment: A commenter questioned how CMS plans to work with state Medicaid agencies regarding implementation of ESRD enrollment in D–SNPs. Specifically, the commenter stated that some states do not permit enrollment into a D–SNP plan when a beneficiary has been diagnosed with ESRD and questioned how CMS plans to address the discrepancy between current state enrollment restrictions prohibiting patients with ESRD from enrolling in a state's D–SNP plans and the removal of the prohibition. The commenter also questioned if CMS will require states to adopt policies or align with CMS' enrollment changes.

Response: States already have the ability in their state Medicaid agency contract with each D–SNP to restrict which dually-eligible individuals may enroll in the D–SNP. If the state's contract with a D–SNP excludes those with ESRD, the D–SNP may retain that exclusion in order to comply with the state contract required under § 422.107.

Comment: A commenter questioned how the enrollment change will affect MMPs. They specifically questioned if CMS and state Medicaid agencies will revise the three-way-contracts and if MMP plan rates would be affected.

Response: We note that currently, most states that are testing a capitated model of integrated care in demonstrations under the Financial Alignment Initiative (FAI) authorized under section 1115A of the Act permit those beneficiaries with ESRD to enroll in MMPs. Only South Carolina and six counties in California exclude those with ESRD from enrolling in an MMP. We are consulting with those two states to determine if, starting CY2021, they want to continue that exclusion under the model of integrated care being tested under the FAI demonstration authority. If they decide they do want to include the ESRD population, CMS would work with those states to update the applicable Medicaid MMP rates, as needed. The MMP Medicare rate structure already includes rates specific for individuals with ESRD and these rates would apply for any MMP enrollees with ESRD; specifically, the ESRD dialysis state rate applies for individuals in the dialysis and transplant status phases, and the Medicare Advantage 3.5 percent bonus county rate applies for individuals in the functioning graft status phase, with all of these rates risk adjusted using the Hierarchical Condition Category -ESRD risk adjustment model for the applicable year.

Comment: A commenter stated that a disproportionate share of beneficiaries with ESRD could be enrolling in D–SNPs and requested that CMS monitor enrollment of beneficiaries with ESRD into D–SNPs and ensure that payments are adequate.

Response: We appreciate the feedback provided by the commenter. We will continue to analyze these issues as additional data emerges. We will consider whether, consistent with the statutory requirements for setting ESRD rates in section 1853(a)(1)(H) of the Act, any refinements to the ESRD rate setting methodology may be warranted in future years.

Comment: A commenter stated that there should be oversight and penalties for companies who use aggressive marketing campaigns to recruit ESRD patients and ''bait and switch'' with services the beneficiary was promised and not delivered.

Response: We appreciate the commenters' concerns. MA plans must comply with the marketing and communications requirements in 42 CFR part 422, subpart V, and specifically, § 422.2268(a)(1) and (2), which include prohibitions on providing information that is inaccurate or misleading, and engaging in activities that could mislead or confuse Medicare beneficiaries. As part of ensuring their compliance with these requirements, MA organizations must monitor and oversee the activities of their subcontractors, downstream entities, and/or delegated entities as well. If CMS finds that MA plans have failed to comply with applicable rules and guidance, CMS may take compliance or enforcement actions, including, but not limited to, intermediate sanctions or civil money penalties.

Comment: Some commenters raised concerns with implementing new rules given the ongoing COVID–19 pandemic and the strain it is putting on the entire United States health care system. A few commenters urged CMS to consider delaying implementation of this change

and continue to prohibit beneficiaries with ESRD from enrolling in MA plans until at least 2022. A commenter requested that CMS consider making all new 2021 requirements voluntary rather than mandatory.

Response: The statutory change provides beneficiaries with the right to make an election for an MA plan if they meet the otherwise applicable requirements beginning January 1, 2021. CMS lacks authority to delay implementation of this statutory change. We are sympathetic to the commenters' concerns that additional changes during the on-going pandemic may increase burdens and make compliance more difficult. However, the pandemic has further indicated that it is important to break down the barrier that has prohibited beneficiaries with ESRD from the enrolling in MA and having access to benefits such as care coordination and limitations to out-of-pocket costs. We also note that these changes are required by law (the Cures Act), effective for plans years on or after 2021. We appreciate that the COVID–19 pandemic has interrupted timing for implementing new requirements, but we are also mindful of the fact that the Cures Act was enacted in 2016 and, as a result, plans have been aware of the change and are likely planning for these enrollments.

Comment: Several commenters suggested that CMS develop educational materials that will provide accurate and objective information about MA plan availability and options, services provided, and potential out-of-pocket costs. A commenter requested that CMS provide clear and easy to understand rules that prohibit discriminatory behavior so that patients that are entitled to Medicare Part A and enrolled in Part B know how they can exercise their right to select an MA plan.

Response: Thank you for the comments. We agree, and as we implement this new and important policy, we will continue to provide educational and outreach materials and other clear guidance to those beneficiaries that are entitled to Medicare Part A and enrolled in Part B. CMS has reviewed, and will continue to review beneficiary publications to identify potential areas for improvement, and update public facing documents as needed so that Medicare beneficiaries are able make an informed coverage choice.

Comment: A commenter stated that it is important for individuals with ESRD to have access to MA plan options through special election periods (SEPs) for exceptional conditions. A commenter stated that an ESRD beneficiary should understand his or her option to change back to Original Medicare. Another commenter noted that if people sign up for MA and they realize it is not the option for them, they should have the ability to modify their enrollment, switch plans, or to cancel and return to Original Medicare.

Response: We agree that beneficiary choice is important and beneficiaries with ESRD—like all other beneficiaries—should carefully consider their enrollment options when they become eligible for Medicare and during subsequent AEPs. All beneficiaries who join an MA plan have opportunities to change plans or return to the original Medicare fee-for-service program during the AEP (October 15 through December 7) or the Medicare Advantage Open Enrollment Period (January 1 through March 31, and during the first three months of Medicare Part A entitlement and Part B enrollment). In some cases, such as when a beneficiary moves out of the service area or is in a plan that does not renew its contract, a SEP is available. Of particular note is the ''SEP65,'' wherein an MA eligible individual who elects an MA plan during his or her initial enrollment period for Part B surrounding his or her 65th birthday may disenroll from this MA plan and elect coverage through the original Medicare fee-for-service program any time during the 12-month period that begins on the effective date of coverage in the MA plan. Beneficiaries may also use SEPs for exceptional conditions newly codified in § 422.62(b)(4) through (25) and described in section 30.4.4 of Chapter 2, Medicare Managed Care Manual, as appropriate, including the SEP for Individuals with ESRD Whose Entitlement Determination Made Retroactively to enroll in an MA plan. Further, to the extent that there is an exceptional situation for an individual that is not addressed by our existing SEPs, codified in this final rule, we will have the ability to respond to the exceptional situation pursuant to § 422.62(b)(26). Finally, there are SEPs available, under § 422.62(b)(3), in situations where the MA plan fails to provide medically necessary services or the plan (or its agents) materially misrepresented the plan's provisions in marketing materials.

Comment: A commenter suggests the establishment of an ESRD ombudsman to address any issues with implementation of this expansion of MA eligibility that may arise for beneficiaries, MA organizations, or their contracted providers.

Response: The Medicare Beneficiary Ombudsman is dedicated to resolving complaints, grievances and requests for information submitted by Medicare-eligible individuals and their advocates concerning any aspect of the Medicare program. Other entities and resources, including the CMS Regional Offices, State Health Insurance Assistance Programs, and 1–800–MEDICARE are also available to assist beneficiaries with issues or questions.

Comment: A commenter proposed that CMS update the enrollment guidance to remove ESRD enrollment restrictions and to release the updated guidance in April. The commenter further states that the technology and process updates necessary for plans to implement the changes and the increase in MA membership has led to an increase in the number of materials that plans need to produce, straining production timelines.

Response: Thank you for the comment. We understand the commenter's concern and plan to issue guidance as soon as possible. We are also mindful of the fact that the Cures Act was enacted in 2016 and, as a result, MA organizations have been aware of this change for some time.

Comment: A commenter suggested that dialysis cost sharing be included in the standard services/items reflected on individual plan searches in the Medicare Plan Finder (MPF) tool, and added that this information is not currently reflected.

Response: We appreciate and agree that this additional data will help Medicare beneficiaries with ESRD find and choose an MA plan. We plan to add this information for plans offering coverage in 2021.

Comment: A couple of commenters agreed with our decision not to amend § 422.66(d)(1) (requiring MA organizations to accept newly eligible Medicare beneficiaries who are seamlessly converting from health plan coverage offered by the MA organization) because the provision already applied to all beneficiaries regardless of their ESRD status. A commenter suggested that CMS slightly modify § 422.66(d)(1) to remove the language, ''(regardless of whether the individual has end-stage renal disease)'' to eliminate any confusion about the prohibition no longer being in effect.

Response: We thank the commenters for their feedback. We believe that the regulation does not require further amendment.

Comment: Commenters also provided a wide range of feedback regarding other downstream issues related to this change in enrollment criteria for the MA program including assurance of adequate payment for plans, quality of

care, HEDIS measure changes, beneficiary MOOP and cost-sharing policies, and network adequacy. A commenter suggested that beneficiaries are likely to have improved outcomes if enrolled in a plan that uses an established care delivery model, and several other commenters requested that CMS allow MA plans to participate in the Center for Medicare & Medicaid Innovation kidney models to improve the dissemination of best practices in kidney care. Another commenter requested that CMS develop and submit SSBCI benefits for these beneficiaries.

Response: We appreciate commenters for their feedback. Since those comments are outside the scope of the changes proposed in §§ 422.50(a)(2), 422.52(c), and 422.110(b), they will not be addressed in this section. To the extent that the comment is about other proposals in the notice of proposed rulemaking, it is, or will be, addressed in connection with that proposal elsewhere in this final rule or a future final rule.

After review and consideration of all comments on the proposal to remove the prohibition on ESRD beneficiaries enrolling in an MA plan and for the reasons in the proposed rule and these comments and responses, we are finalizing the revisions to §§ 422.50(a)(2), 422.52(c), and 422.110(b) as proposed.

B. Medicare Fee-for-Service (FFS) Coverage of Costs for Kidney Acquisitions for Medicare Advantage (MA) Beneficiaries (§ 422.322)

The MA organization is generally responsible for furnishing or providing coverage of all Medicare Part A and Part B benefits, excluding hospice, for its enrollees. The Medicare FFS program does not pay health care providers for furnishing these benefits to such enrollees. Section 1851(i) of the Act generally provides that, subject to specific exceptions, CMS pays only the MA organization for the provision of Medicare-covered benefits to a Medicare beneficiary who has elected to enroll in an MA plan. There are specific, statutory exceptions to this general rule in the statute, such as authority in section 1853(h) of the Act for FFS Medicare payment for Medicare-covered hospice services that an MA plan is prohibited by statute from covering. Section 17006(c) of the Cures Act amended section 1852(a)(1)(B)(i) of the Act to exclude from the list of items or services an MA plan is required to cover for an MA enrollee coverage for organ acquisitions for kidney transplants, including as covered under section 1881(d) of the Act. Effective January 1, 2021, these costs will be covered under the original Medicare FFS program, pursuant to an amendment by section 17006(c)(2) of the Cures Act to section 1851(i) of the Act. As amended, section 1851(i)(3) of the Act authorizes FFS Medicare payment for the expenses for organ acquisitions for kidney transplants described in section 1852(a)(1)(B)(i) of the Act. We proposed conforming regulatory changes to reflect the revision to the statute.

Specifically, we proposed to revise § 422.322, which describes the source of payment and effect of MA plan election on payment for Medicare-covered benefits. Paragraphs (b) and (c) of § 422.322 generally track the statutory requirements that, subject to specific exceptions, CMS payment to MA organizations is in lieu of the amounts that would otherwise be payable under the original Medicare FFS program for Medicare-covered benefits furnished to an MA enrollee and are the only payment by the government for those Medicare-covered services. Consistent with the amendments to sections 1851(i) and 1852(a)(1)(B)(i) of the Act, we proposed to amend § 422.322 to add a new paragraph (d) to reflect that expenses for organ acquisitions for kidney transplants are an exception to the terms outlined in paragraphs (b) and (c), and will be covered by original Medicare. Our new paragraph (d) generally tracks how section 17006(c) of the Cures Act amends section 1851(i)(3) of the Act.

The Cures Act does not provide for Medicare FFS coverage of organ acquisition costs for kidney transplants incurred by PACE participants. Therefore, PACE organizations must continue to cover organ acquisition costs for kidney transplants, consistent with the requirement described in section 1894(b)(1)(A)(i) of the Act that PACE organizations provide all Medicare-covered items and services. Accordingly, CMS will continue to include the costs for kidney acquisitions in PACE payment rates.

The following is a summary of the comments we received and our responses:

Comment: Several commenters expressed support for the implementation of this Cures Act requirement.

Response: We appreciate the commenters' support of our approach to implementing this change.

Comment: A commenter encouraged CMS to monitor the effects of the proposal's approach to organ acquisition costs.

Response: While we will continue to monitor and analyze the impact of this change, we must comply with the statutory requirement for FFS Medicare to cover kidney acquisition costs for MA beneficiaries.

Comment: A commenter noted that neither the proposed rule nor the calendar year 2021 Advance Notice, which was published on February 5, 2020, provided clear guidance on billing and reimbursement for organ acquisition costs. This commenter urged CMS to clarify whether these services are to be billed directly to Medicare Administrative Contractors (MACs) and paid directly to the providers involved, rather than being paid to MA plans for pass-through to providers. The commenter also requested that CMS clarify which organ acquisition costs will be payable by FFS Medicare.

Response: We appreciate the commenter's request for further clarification. We want to emphasize that the payment changes for organ acquisition costs apply only to kidneys. Effective January 1, 2021, FFS Medicare will cover kidney acquisition costs for MA beneficiaries in accordance with the processes and guidance outlined in the Claims Processing Manual,[17] CMS Pub. 100–04, chapter 3 and the Provider Reimbursement Manual,[18] CMS Pub. 15–1, chapter 31. Hospitals currently bill MA claims to their respective MACs for processing as no-pay bills so that the MA inpatient days can be accumulated on the Provider Statistics & Reimbursement Report (PS&R) (report type 118). These no-pay bills must identify kidney acquisition costs using revenue code 081X and the hospital must track each MA kidney transplant. For instructions on billing for kidney acquisition costs, please refer to chapter 3, sections 90.1 through 90.1.3, of the Claims Processing Manual. For details on services included as kidney acquisition costs, please refer to chapter 31, section 3101, of the Provider Reimbursement Manual. The MA kidney transplants will be used in the numerator and denominator on the Medicare cost report to determine Medicare's share of kidney acquisition costs. Final payment will be made to the hospital through the Medicare cost report.

Comment: A commenter questioned how CMS addresses the difference between cadaveric organ acquisition and living donor organ donation in assessing kidney acquisition.

[17] *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs-Items/CMS018912.*

[18] *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.*

Response: We appreciate the commenter's question. Please refer to the Provider Reimbursement Manual, CMS Pub. 15–1, chapter 31,[18] for more information on provider reimbursement for the costs related to acquiring living donor organs and cadaveric donor organs.

After careful consideration of all comments received and for the reasons outlined in the proposed rule and our responses to comments, we are finalizing the regulatory changes to § 422.322 to conform with the statutory amendments requiring FFS Medicare coverage of kidney acquisition costs for MA beneficiaries, effective January 1, 2021.

C. Exclusion of Kidney Acquisition Costs From Medicare Advantage (MA) Benchmarks (§§ 422.258 and 422.306)

Section 17006(b) of the Cures Act amended section 1853 of the Act to require that the Secretary's estimate of standardized costs for payments for organ acquisitions for kidney transplants be excluded from Medicare Advantage (MA) benchmarks and capitation rates, effective January 1, 2021. As amended, section 1853(k)(5) of the Act provides for the exclusion from the applicable amount and section 1853(n)(2) provides for the exclusion from the specified amount of the Secretary's estimate of the standardized costs for payments for organ acquisitions for kidney transplants covered under the Medicare statute (including expenses covered under section 1881(d) of the Act). As discussed in greater detail in the Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Other Changes Final Rule (hereinafter referred to as the April 2011 final rule) (76 FR 21431, 21484 through 21485) and the annual Advance Notices and Rate Announcements starting with Payment Year 2012,[19] the applicable amount and the specified amount are used in the calculation of the MA benchmarks and capitation rates. We proposed to revise the relevant regulations to reflect these amendments.

Specifically, we proposed to revise § 422.258, which describes the calculation of MA benchmarks. Under section 1853(n)(1)(B) of the Act and § 422.258(d) of the regulations, for 2012 and subsequent years, the MA benchmark for a payment area for a year is equal to the amount specified in section 1853(n)(2) of the Act (that is, the ''specified amount''), but, as described in section 1853(n)(4) of the Act and § 422.258(d)(2)(iii), cannot exceed the applicable amount specified in section 1853(k)(1) of the Act and § 422.258(d)(2). Prior to enactment of the Cures Act, section 1853(n)(2)(A) of the Act described the specified amount as the product of the base payment amount for an area for a year (adjusted to take into account the phase-out in the indirect costs of medical education from capitation rates) and the applicable percentage for the area and year. The base payment amount is, for years after 2012, the average FFS expenditure amount specified in § 422.306(b)(2). Section 17006(b)(2)(A) of the Cures Act amended section 1853(n)(2)(A)(i) of the Act to require that, for 2021 and subsequent years, the base payment amount used to calculate the specified amount must also be adjusted to take into account the exclusion of payments for organ acquisitions for kidney transplants from the capitation rate. We proposed to make conforming amendments to paragraphs (d)(3), (5), and (6) of § 422.258. As amended, paragraph (d)(3) would specify that for 2021 and subsequent years, the base payment amount used to calculate the specified amount is required to be adjusted to take into account the exclusion of payments for organ acquisitions for kidney transplants. Also, as amended, paragraphs (d)(5) and (6) would specify that the average FFS expenditure amount used to determine the applicable percentage is adjusted to take into account the exclusion of payments for organ acquisitions for kidney transplants. To make these amendments, we proposed to insert references to the adjustment made under § 422.306(d) to modify the various references to the base payment amount in paragraphs (d)(3), (d)(5), (d)(5)(i) and (ii), and (d)(6).

We proposed to amend § 422.306 by revising the introductory text and adding a new paragraph (d). Proposed paragraph (d) described the required adjustment, beginning for 2021, to exclude the Secretary's estimate of the standardized costs for payments for organ acquisitions for kidney transplants covered under this title (including expenses covered under section 1881(d) of the Act) in the area for the year. By operation of § 422.258(d)(2), the applicable amount is established by reference to § 422.306 and the rules there for calculation of MA annual capitation rates. By adding § 422.306(d), we would implement the new language in section 1853(k)(5) of the Act (added by section 17006(b)(1)(B) of the Cures Act) to require the adjustment to exclude payments for organ acquisitions for kidney transplants. We requested comment on whether these proposed revisions to §§ 422.258(d) and 422.306 adequately implement the statutory changes made by section 17006 of the Cures Act to require exclusion of the costs of kidney acquisition from the applicable amount and the specified amount for purposes of setting MA benchmarks and capitation rates.

Per section 1853(a)(1)(H) of the Act, CMS is required to establish separate rates of payment to an MA organization for individuals with end stage renal disease (ESRD) who are enrolled in a plan offered by that organization. This special rule for ESRD payment rates is codified in the regulations at 42 CFR 422.304(c). Since the Cures Act requires FFS Medicare payment for kidney acquisition costs for all MA enrollees, including MA enrollees with ESRD, we proposed to apply the exclusion of kidney acquisition costs to the ESRD payment rates. As § 422.304(c) does not prescribe the specific methodology CMS must use to determine the separate rates of payment for ESRD enrollees described in section 1853(a)(1)(H) of the Act, the exclusion of kidney acquisition costs from ESRD rates does not require regulatory amendment. CMS addressed the methodology for excluding kidney acquisition costs from MA benchmarks (including the MA ESRD state rates) in the 2021 Advance Notice and Rate Announcement.

Section 1894(d)(2) of the Act requires that PACE capitation amounts be based upon MA payment rates established under section 1853 of the Act and adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. While capitated payments made to PACE organizations are based on the applicable amount under section 1853(k)(1) of the Act, we will include the costs for kidney acquisitions in PACE rates. Because PACE organizations are required to cover all Medicare-covered items and services under section 1894(b)(1)(A)(i) of the Act, including organ acquisition costs for kidney transplants, we will include kidney acquisition costs in PACE payment rates, including PACE ESRD rates. This approach is consistent with how PACE organizations have historically been paid for kidney acquisition costs for PACE enrollees. We did not propose any regulatory amendments to address this.

[19] The Advance Notice and Rate Announcement for each year are available online at: *https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.*

We appreciate commenters' feedback on our approach to implementing this Cures Act requirement. We received the following comments on our proposed regulatory changes, to which we provide responses below:

Comment: Numerous commenters expressed concerns about the methodologies for excluding kidney acquisition costs from MA benchmarks and for developing MA ESRD state rates. Several commenters requested additional transparency and data regarding the carve-out methodology, voiced concerns about the magnitude of the carve-out, and provided suggestions for alternative ways to calculate and apply the kidney acquisition adjustment. A commenter specifically noted that if the kidney acquisition carve-out amounts were to be artificially high, excluding these costs from MA benchmarks would exacerbate the perceived issues of underpayment in MA for ESRD beneficiaries.

Response: Section 1853(b) provides for CMS to use the annual Advance Notice to provide notice of proposed changes to be made in the methodology for the MA capitation rates and risk adjustment factors from the methodology and assumptions used in the previous announcement. As discussed, the kidney acquisition carve-out is part of the methodology for developing the MA capitation rates. Pursuant to the statute, CMS proposed the methodology for calculating the kidney acquisition costs to be excluded from the MA benchmarks in the 2021 Advance Notice by providing a step-by-step description of the calculations to be used to adjust the rates. CMS also detailed in the calendar year 2021 Advance Notice the methodology used to develop ESRD state rates. After considering all public comments received and consistent with the statutory requirement to exclude the cost of kidney acquisitions for organ transplants from the primary components of the MA capitation rates, CMS finalized the kidney acquisition carve-out methodology, as well as the ESRD rate methodology, in the calendar year 2021 Rate Announcement. Similar comments regarding the need for transparency and accuracy in calculating the kidney acquisition cost, the methodology used by CMS, and the amount of payment to MA plans were raised in that context and addressed by CMS in the calendar year 2021 Rate Announcement. We direct readers to that document for a more detailed discussion of these issues.

Comment: A commenter requested that CMS explain whether the exclusion of kidney acquisition costs from MA benchmarks has an impact on Medicare-Medicaid Plans (MMPs).

Response: CMS develops annual Medicare capitation rates used for MMP payment. The MMP capitation rates are based on an estimate of what would have been spent in the payment year had the demonstration not existed. Beneficiaries enroll in the MMP demonstrations from both MA and Medicare FFS, and therefore the MMP Medicare capitation rates are developed with a weighted average of these populations' spending assumptions, proportional to the combination of enrolled dually eligible beneficiaries. Therefore, the MMP Medicare capitation rates are developed using both the published Medicare standardized FFS county rates (which are part of the MA ratebook calculation files that are released with the annual Rate Announcement) and an MA component that is based on MA plans' bids and rebates.

As discussed in the calendar year 2021 Rate Announcement, kidney acquisition costs will be carved out of the contract year 2021 Medicare standardized FFS county rates. MA plans will bid against benchmarks that exclude kidney acquisition costs, in accordance with the statutory amendments to sections 1853(k) and (n); this is also consistent with how MA plans are no longer responsible for the costs of kidney acquisitions. Therefore, both components of the MMP Medicare capitation rate (the Medicare standardized FFS county rates and the MA component of the MMP rate) will exclude kidney acquisition costs. MMPs (like MA plans) will no longer be responsible for organ acquisition costs for kidney transplants; such costs will be excluded from the MMP rates and instead covered under Medicare FFS.

Comment: A commenter noted that plans will need to re-contract for transplant services to remove the cost of kidney acquisitions. This commenter explained that it is unlikely that the new contracts will carve out costs that are comparable to (or lower than) the costs being removed from the MA benchmarks. This commenter also requested the precise amounts CMS has paid on behalf on MA enrollees to each provider.

Response: We appreciate the commenter's concerns regarding this issue but must comply with the statutory requirement to exclude kidney acquisition costs from MA benchmarks. To date, CMS has paid for kidney acquisition costs for MA beneficiaries through the county and ESRD state rates in the MA ratebooks.

Comment: Numerous commenters noted concerns about the adequacy and accuracy of the ESRD rates as well as the perceived underfunding of the underlying ESRD PPS. A few commenters also requested that CMS consider various options related to payment for dialysis services, including the establishment of a fee schedule cap for dialysis centers, implementation of zero cost sharing for dialysis services, and provision of an incentive payment for MA plans to offer home dialysis.

Response: As these comments did not address the impact, implementation, or consequences of the kidney acquisition carve-out required by the Cures Act, they are out of the scope of this rulemaking.

After careful consideration of all comments received and for the reasons outlined in the proposed rule and out responses to the comments, we are finalizing the proposed changes to § 422.258(d)(3), (d)(5) introductory text, (d)(5)(i) introductory text, (d)(5)(ii), and (d)(6)(i) and the introductory text of § 422.306 and paragraph (d).

IV. Enhancements to the Part C and D Programs

A. Reinsurance Exceptions (§ 422.3)

Section 1855(b) of the Act requires MA organizations to assume full financial risk on a prospective basis for the provision of basic benefits (and, for plan years before 2006, additional benefits required under section 1854 of the Act) furnished to MA plan enrollees, subject to the exceptions listed in the statute at section 1855(b)(1)–(4) of the Act. The exception at section 1855(b)(1) of the Act states that an MA organization may obtain insurance or make arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds a per-enrollee aggregate level established by the Secretary. Section 1855(b)(1) of the Act describes stop loss insurance arrangements but we explained in the proposed rule that our proposal did not use those terms in order to be specific in describing the form of the arrangement. Section 1855(b)(1) of the Act permits an MA organization to obtain insurance or make other arrangements under which the MA organization bears less than full financial risk for the costs of providing basic benefits for an individual enrollee that exceed a certain threshold. In the proposed rule, we proposed to adopt a new § 422.3 to implement the exception at section 1855(b)(1) of the Act and establish in regulation options for MA organizations to use insurance for costs beyond a specified threshold. We

proposed that an MA organization may obtain insurance (that is, reinsurance) or make other arrangements for the cost of providing basic benefits to an individual enrollee the aggregate value of which exceeds $10,000 during a contract year or, alternatively, such costs may be shared proportionately on a first dollar basis, the value of which is calculated on an actuarially equivalent basis to the value of the insurance for costs that exceed $10,000 in a contract year. We also proposed that if the MA organization chooses to purchase pro rata coverage that provides first dollar coverage, the value of that coverage cannot exceed the value of the option of purchasing stop loss insurance for enrollee health care costs that exceed a threshold of $10,000 in a contract year. We noted in the proposed rule that the statutory exceptions at section 1855(b)(2) through (b)(4) of the Act still apply and that our proposal would serve to establish in regulation the threshold described in section 1855(b)(1) of the Act.

Because we interpret section 1855(b) of the Act as requiring an MA organization to remain at full financial risk for basic benefits, subject to the exceptions listed in subsections (b)(1) through (b)(4), we proposed that the limits in § 422.3 apply for purposes of insuring (or making other arrangements) for costs of providing basic benefits in excess of the established threshold and that those limits would not apply to supplemental benefits offered by MA organizations. We proposed to implement the exception at section 1855(b)(1) of the Act because of concerns raised to CMS that absent the implementation of specific standards by CMS under section 1855(b)(1) of the Act, there was ambiguity about the legal basis of MA organizations sharing risk through reinsurance. We noted in our proposed rule that a number of MA organizations expressed concern to CMS about this legal uncertainty as they have utilized reinsurance within the MA program. To resolve this uncertainty, we proposed to formally establish reinsurance standards implementing section 1855(b)(1) of the Act. Our proposal was generally not about subsections (b)(2) through (b)(4) of section 1855 of the Act.

Under our proposed implementation of the exception at section 1855(b)(1) of the Act, MA organizations that voluntarily choose to purchase insurance to limit their exposure to losses in furnishing basic benefits to individual enrollees would have two options. In the first option, an MA organization could purchase insurance (or make other arrangements) that would stop losses for the MA organization for individual plan enrollees when an individual enrollee's covered costs for basic benefits exceed $10,000 during a contract year. Stated another way, the MA organization could have insurance for costs that exceed $10,000 for covering or furnishing basic benefits to an individual plan enrollee in the contract year. In the second option, an MA organization could purchase pro rata insurance coverage that would provide first dollar coverage provided that the value of the insured risk is actuarially equivalent to costs that exceed $10,000 and the insurance coverage is priced at an actuarial value not to exceed the value of the stop loss insurance for medical expenses exceeding $10,000 per member per year. Specifically, the value of first dollar pro rata insurance could not exceed the value of $10,000 per member per year stop loss insurance.

In the proposed rule, we noted that in discussions with the National Association of Insurance Commissioners (NAIC) and in 2018 Call Letter comments we previously received, CMS was advised that the use of insurance by health care insurers is a common and long standing market practice for both commercial health insurers and MA organizations and that the practice has the purpose of reducing financial exposure to changes in health care costs, helps manage capital requirements, and allows health care insurers to grow enrollment. As we explained in our proposed rule, discussions with the NAIC and earlier information we received from the industry indicated that MA organizations located in areas with fewer beneficiary choices (for example, rural, underserved areas) particularly benefit from access to reinsurance because of how it provides financial stability for the MA organization, which in turn can lead to enhanced competition and consumer choice, especially in small and mid-sized market areas. Insuring part of the risk assumed under an MA plan is important for smaller MA organizations to compete with larger organizations that can independently finance their operations.

We also noted that excessive reinsurance can be viewed as a hazard to the extent that the direct health insurer (here, the MA organization) might pass such a large share of their risk and premium through insurance and that the MA organization could then be viewed as no longer possessing the primary responsibility for furnishing the health care services. We further explained in our proposed rule that while the statute identifies the category of risk for which an MA organization may seek insurance or other arrangements (such as, in section 1855(b)(1) of the Act, the cost of providing to any enrolled member such services the aggregate value of which exceeds an established threshold), it is in the context of a mandate that MA organizations assume full financial risk on a prospective basis for providing basic benefits to enrollees. We stated that we are cognizant of the need to ensure that MA organizations are not transferring all the risk of providing services to enrollees to a third party that is not under contract with CMS. We also stated that we seek to balance these different interests in setting the threshold for the individual stop loss insurance coverage authorized by the statute.

We also explained that the $10,000 threshold we proposed has its roots in our review of the Conference Report for the BBA of 1997 (H.R. Conf. Rep. 105–217) and the difference between the House bill and the Senate amendment on the threshold at which a Part C plan could reinsure per-enrollee costs. The Conference Report indicates that the House bill tracked existing language in section 1876(b)(2)(D)(i) of the Act in using a $5,000 per year threshold while the Senate amendment provided for an amount established by the agency with an annual adjustment using the Consumer Price Index-Urban (CPI–U) for the 12-month period ending with June of the previous year. The conference agreement was to adopt the language in section 1855(b)(1) of the Act that remains today: A threshold established by the agency from time to time. To develop the $10,000 threshold we are proposing, we started with the amount of $5,000 identified in the Conference Report and used the following methodology: We multiplied the amount identified in the Conference Report ($5,000) by the increase in the CPI–U. Our policy choice was heavily influenced by the description in the Conference Report of the Senate amendment: ''the applicable amount of insurance for 1998 is the amount established by the Secretary and for 1999 and any succeeding year, is the amount in effect for the previous year increased by the percentage change in the CPI-urban for the 12-month period ending with June of the previous year.'' In updating the threshold this way, we rounded the amount for each year to the nearest whole dollar. Actual CPI–U values through June 2019 were used to perform these calculations. After 2019, the CPI–U values are estimated using the Congressional Budget Office's

August 2019 report: An Update to the Economic Outlook: 2019 to 2029.

In our discussion, we stated that based on a scan of the market and current practices of commercial health insurers, we believed that the $10,000 threshold for stop loss insurance that we proposed reflected a level of risk transfer that was reasonable and consistent with supporting robust competition in Medicare Advantage. We also explained our positon that the proposed level of risk transfer would be acceptable given that CMS closely monitors MA organizations in terms of their administration of their MA plans, specifically their timely provision of medically necessary health care services to enrollees and their overall financial solvency. We further clarified that CMS has a direct contract with each MA organization and despite any insurance arrangements, the MA organization remains responsible and liable to each individual enrollee for furnishing the covered benefits. In addition, we explained that CMS through its regional offices, plan audits, review of enrollee appeals and stakeholder letters closely monitors the performance of MA organizations and intervenes whenever it has evidence an MA organization is not meeting its contractual obligations. We also noted that any insurance arrangement used by MA organizations is subject to state insurance regulation and oversight regarding solvency because section 1856(b)(3) of the Act does not preempt those solvency laws or provide that CMS regulation supersedes them. We noted our understanding that the NAIC model laws (Model 785); NAIC Credit for Reinsurance Regulation (Model 786); and the NAIC Life and Health Reinsurance Agreements Model Regulation (Model 791) have been substantially adopted by all states. We believe the wide adoption of the NAIC reinsurance model laws by states ensures reasonable consistency for MA organizations subject to reinsurance review as part of the state's financial solvency determination. Finally, we stated that CMS oversight along with the states' oversight of financial solvency substantially would ensure that CMS would be able to intervene on a timely basis when an MA organization is experiencing solvency problems or is not meeting its obligation to appropriately furnish its enrollees with benefits covered under the MA plan.

We also acknowledged that the reinsurance marketplace is complex and evolving. Therefore, we asked for comments regarding our proposed reinsurance regulation generally and the specific threshold proposed. We stated that we were particularly interested in comments whether the $10,000 threshold is a reasonable level and if the flexibility we proposed for MA organizations in permitting insurance or other arrangements that are actuarially equivalent to the $10,000 threshold for individual medical costs is sufficient to remove the uncertainty about the use of reinsurance by MA organizations. We also solicited comments that would provide additional information about insurance or other arrangements for addressing the risk of costs that exceed specific thresholds on an individual enrollee basis.

In our proposed rule, we also explained that we would consider an MA organization to include its parent organization when evaluating compliance with the proposed standard for reinsurance and compliance with the statute. The result of that would be to evaluate compliance with section 1855(b) of the Act (not just subsection (b)(1)) and proposed § 422.3 at the parent organization level, such that risk sharing or allocations of losses and costs among wholly-owned subsidiaries would not be evaluated. We requested comments on this approach and whether CMS should consider a parent organization to be part of an MA organization for purposes of section 1855(b) of the Act or whether CMS should consider a parent organization to be a separate entity from an MA organization.

We thank commenters. We received 13 comments on this proposal; we summarize these comments and our responses follow:

Comment: Several commenters were generally supportive of § 422.3(a)(1) affirming the ability of MA organizations to purchase stop loss insurance for basic Medicare covered medical expenses for an individual enrollee that exceed with an aggregate value of $10,000 or more per member per year in any year. However, several commenters expressed concerns about the proposed pro rata insurance requirement at § 422.3(a)(2), requiring that this option not exceed the actuarial cost of purchasing stop loss insurance for enrollee health care costs that exceed a threshold of $10,000 in a contract year. A commenter stated that they read the proposed regulation as requiring that the value of the insured risk does not exceed a value which is actuarially equivalent to the aggregate value of the costs of providing basic benefits to an individual enrollee which exceeds an aggregate level that is greater than or equal to $10,000 during a contract year. The commenter said that they found this language difficult to follow. This commenter also said that, further complicating the matter, excess of loss insurance (that is, stop loss) and first dollar proportional (that is, pro rata) insurance are very different forms of reinsurance. Other commenters were also concerned that because of the differences in these types of insurance it would be difficult calculating an actuarial value for the cost of purchasing annual pro rata insurance, which shares costs with an insurer on a first dollar proportional basis. The commenters also said that their uncertainly about how to calculate this actuarial equivalency would make it difficult for them to ensure they would be in compliance with the proposed regulatory requirement. Several commenters recommended that instead of an actuarial equivalence that we set a limit on the amount of risk that an MA organization would be allowed to transfer to a reinsurer. Several commenters specifically proposed that CMS adopt a 10 percent standard under which an MA organization would be required to maintain a minimum of 10 percent of the financial risk in any reinsurance arrangement involving the sharing of costs proportionately with an insurer on a pro rata first dollar basis.

Response: We agree that the reinsurance options under proposed § 422.3(a)(1) and (2) are different and acknowledge this potentially creates uncertainty and difficulties in determining actuarial equivalency, as pointed out by the commenters. As we noted above the statute permits an MA organization to use insurance or make other arrangements for the cost of providing basic benefits to an individual enrollee that exceed a certain threshold. In order to provide an option for using insurance or other arrangements for some of the cost of providing basic benefits to an individual enrollee before the threshold is exceeded, we sought to establish a way to equate the $10,000 stop loss threshold to sharing the risk proportionally on a first dollar basis (that is, pro rata insurance) to provide additional flexibility to MA organizations while ensuring compliance with the statute.

In considering these comments we appreciate that there could be difficulty for some organizations in determining whether and when the two reinsurance options were actuarially equivalent or in determining an actuarially equivalent dollar amount for the two reinsurance options. We also recognize that it would be administratively simpler if we were to adopt a single standard for the amount of risk an MA organization can transfer to an insurer under this regulation. As we discuss below we are finalizing regulation text to clarify how

MA organizations can make an actuarial equivalency determination between the $10,000 stop loss insurance option and the option to purchase first dollar proportional (that is, pro rata) insurance. In addition, we have determined that the ability to purchase pro rata insurance affords the MA organizations the necessary flexibility to purchase different types of reinsurance. We are specifically finalizing this regulation to allow an MA organization to have insurance or make another arrangement for the cost of providing basic benefit to an enrollee, the aggregate value of which exceed an aggregate value that is equal to or greater than $10,000. In effect, an MA organization can have stop-loss insurance per enrollee with a $10,000 attachment point. In addition, the MA organization may use insurance to share costs proportionately on a per member per year first dollar basis as long as the amount of risk retained by the MA organization is actuarially equivalent to the risk retained in purchasing $10,000 per member per year first dollar stop loss insurance. To specifically address the concerns about actuarial equivalence valuations we have determined that actuarial equivalence may be calculated as the expected percentage of the MA organization's claim cost of providing basic benefits to an individual enrollee that is greater than or equal to $10,000 during a contract year. The MA organization may share its costs proportionately on a first dollar basis up to the expected percentage. For example, assume that the actuarially supported expected percentage is 66 percent. In this example, the MA organization may reinsure (cede) up to 66 percent of such costs proportionately on a first dollar basis. However, we recognize that there are other reasonable actuarial approaches that could be used to determine the actuarial equivalence cost when purchasing pro rata insurance. We will accept approaches that are based on a reasonable actuarial methodology. An MA organization may also value its pro rata insurance by establishing a specific percentage level of risk that it can reinsure that is not more than the actuarial value of $10,000 individual stop loss insurance. Appreciating that some commenters indicated that the proposed regulation text describing the permissible stop-loss arrangement was confusing, we are clarifying this in the final regulation text. The regulation now states the permissible insurance or other arrangement by describing the permissible reinsurance or other arrangement in terms of how much and which financial risk the MA organization must retain: The MA organization must retain the risk for at least the first $10,000 in costs of providing basic benefits per individual enrollee during the contract year.

To specifically address the concerns about actuarial equivalence valuations, we are finalizing regulation text to clarify that MA organization may make a determination of actuarial equivalence based on reasonable actuarial methods. We are finalizing that an MA organization may share the costs of providing basic benefits on a per member per year first dollar basis when: (i) The actuarial value of the risk retained by the MA organization is actuarially equivalent to the value of the risk that must be retained using the permissible stop-loss arrangement that is described in paragraph (a)(1) and (ii) the determination of actuarial equivalence is based on reasonable actuarial methods. For example, actuarial equivalence may be reasonably calculated using the expected percentage of the MA organization's claim cost of providing basic benefits to an individual enrollee that is greater than or equal to $10,000 during a contract year. The MA organization may share its costs proportionately on a first dollar basis up to that expected percentage. For example, assume that the actuarially supported expected percentage is 66 percent. In this example, the MA organization may reinsure (cede) up to 66 percent of such costs proportionately on a first dollar basis. However, we recognize that there are other reasonable actuarial approaches that could be used to determine the actuarial equivalence cost when purchasing pro rata insurance. We will accept approaches that are based on a reasonable actuarial methodology. An MA organization may also value its pro rata insurance by establishing a specific percentage level of risk that it can reinsure that is not more than the actuarial value of $10,000 individual stop loss insurance.

Comment: Several commenters asked for clarification about the applicability of the proposed reinsurance rule, asking if it would apply to quota share reinsurance arrangements under section 1855(b)(1) of the Act alone, or will it also apply to quota share reinsurance arrangements under subsections (b)(2), (b)(3) and (b)(4) of section 1855 of the Act as well. The commenters wanted to know if quota share arrangements would be permissible only in the specific circumstances described in our proposed rule to implement section 1855(b)(1) of the Act.

Response: Our proposal and this final rule at § 422.3(a) are specifically about implementing section 1855(b)(1) of the Act. Section 1855(b)(1) permits MA organizations to insure or make other arrangements for the cost of providing to any enrolled member basic benefits the aggregate value of which exceed a threshold set by the agency. We proposed that threshold ($10,000) and a way that MA organizations could share *that particular risk* proportionately by tying the parameters for the proportionate-risk arrangement to the actuarial value of the financial risk where the stop loss threshold is over $10,000.

MA organizations are only permitted to share risk proportionally so long as the risk (the type and amount) is in the statutory exceptions at section 1855(b) of the Act. Section 1855(b) of the Act describes types of risk for which an MA organization may use insurance or make other arrangements. For example, section 1855(b)(2) permits an MA organization to obtain insurance or make other arrangements for the cost of basic benefits provided to its enrollees other than through the organization because medical necessity required the provision of those basic benefits before that organization could furnish them; an MA organization could use insurance to cover all of the costs described in subsection (b)(2), use a quota share arrangement for those costs, or use some other reinsurance arrangement for those costs. However, section 1855(b)(2) only permits the use of reinsurance or risk sharing arrangements for those specifically described costs. Our proposal and this final rule at § 422.3(a) do not address the other statutory exceptions at section 1855(b) of the Act.

Comment: Several comments asked that CMS acknowledge that CMS policy has, in the past, permitted MA organizations to utilize quota share reinsurance arrangements with captive insurance companies and risk bearing entities including provider-affiliated captive insurance companies, or other risk-bearing entities under the authority of section 1855(b)(4) of the Act, and that CMS will continue to allow this. Commenters also asked that CMS further clarify whether the provider-affiliated entity must be wholly-owned by the provider, or whether a lower percentage of ownership is required.

Response: Section 1855(b)(4) of the Act permits an MA organization to make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for basic benefits

furnished by such physicians, by such other health professionals or through such institutions. The type of payment arrangement used between the MA organization and contracting physicians, other health professionals or institutions for this specified financial risk is not limited by § 422.3(a). To be clear on this point, we are finalizing § 422.3(c) to state that the type of payment arrangement between an MA organization and contracting physicians, other health professionals or institutions for the financial risk on a prospective basis for the provision of basic benefit by those physicians or other health professionals or through those institutions) is not limited by § 422.3(a).

Comment: Two commenters asked if reinsurance options under § 422.3(a)(1) and (2) can also include MA supplemental benefits. A commenter stated that it is operationally very challenging to separate the revenues and expenses associated with supplemental benefits from the revenues and expenses associated with basic benefits.

Response: As we stated in the proposed rule, we interpret section 1855(b) of the Act as requiring an MA organization to remain at full financial risk for basic benefits, subject to the exceptions listed in subsections (b)(1) through (b)(4). The limits in proposed § 422.3(a) and finalized in this rule apply for purposes of insuring (or making other arrangements) for costs of providing basic benefits and therefore do not apply to supplemental benefits offered by MA organizations. MA organizations are not prohibited from obtaining reinsurance for supplemental benefits and this final rule does not limit either the form or amount of reinsurance for supplemental benefits.

Comment: Commenters were supportive of our proposal with respect to section 1855(b) to broaden our interpretation of MA organization to include the parent organization. This would mean that CMS would evaluate compliance with 1855(b) of the Act and proposed § 422.3 at the parent organization level, such that risk sharing or allocations MAO of losses and costs among wholly-owned subsidiaries would not be evaluated. Commenters also asked if CMS will accommodate situations where an MA organization obtains reinsurance from captive insurance companies, an affiliate and/or a joint venture or alliance partner. A commenter noted that reinsurance is a useful means by which to share profits/losses in joint ventures and alliances, an entity may choose to allocate its risk to a reinsurer that is an affiliate of the MA organization and to another joint venture or alliance partner. The comment states that these arrangements serve as a mechanism to facilitate the allocation of profits/losses under a joint venture or alliance.

Response: In this final rule we are affirming that for purposes of 1855(b) of the Act and for § 422.3, we will evaluate compliance at the parent organization level, such that risk sharing or allocations of losses and costs among wholly-owned subsidiaries will not be evaluated. These internal arrangements would be treated as the MA organization retaining full financial risk for the losses or risks that are covered through the internal arrangement. We are adding language to the final regulation at § 422.3(b) confirming this position. Reinsurance arrangements facilitated for purposes of joint venture and alliance partner must comply with 1855(b) of the Act, CMS regulations and requirements, other federal laws and regulations, and state laws and requirements.

We thank the commenters for sharing their concerns and recommendations regarding our proposed implementation of Section 1855(b)(1) in the MA regulations at § 422.3. After careful examination of all comments received and for the reasons set forth in the proposed rule and our responses to comments, we are finalizing § 422.3 with modifications from the proposal. As finalized, paragraph (a) provides that an MAO may obtain insurance or make other arrangements for the cost of providing basic benefits to an individual enrollee during the contract year in one of two ways. We are finalizing § 422.3(a)(1) to permit an MA organization to use insurance or make other arrangements for the cost of providing basic benefits to an individual enrollee during the contract year so long as the MA organization retains risk for at least the first $10,000 of that cost. We are finalizing § 422.3(a)(2)(i) permitting reinsurance on a per member per year first dollar basis so long as the MA organization retains at least an amount of risk that is actuarially equivalent to the value of risk retained in paragraph (a)(1). We also clarify in the final regulation at § 422.3(a)(2)(ii) that MA organizations obtaining such reinsurance under the option described at § 422.3(a)(2)(i) may utilize any reasonable actuarial methodology to determine actuarial equivalence.

We are also adding § 422.3(b) clarifying that CMS will consider a parent organization to be part of an MA organization for purposes of section 1855(b) of the Act. Finally, we are adding regulation text at § 422.3(c) to clarify the type of payment arrangement used between an MA organization and contracting physicians, other health professionals or institutions for the financial risk specified in section 1855(b)(4) of the Act is not limited by paragraph (a).

B. Medicare Advantage (MA) and Part D Prescription Drug Program Quality Rating System (§§ 422.162, 422.166, 423.182, and 423.186)

1. Introduction

In the April 2018 final rule, CMS codified at §§ 422.160, 422.162, 422.164, and 422.166 (83 FR 16725 through 83 FR 16731) and §§ 423.180, 423.182, 423.184, and 423.186 (83 FR 16743 through 83 FR 16749) the methodology for the Star Ratings system for the MA and Part D programs, respectively. This was part of the Administration's effort to increase transparency and give advance notice regarding enhancements to the Part C and D Star Ratings program. CMS must propose through rulemaking any future changes to the methodology for calculating the ratings, addition of new measures, and substantive changes to the measures. Sections 422.164(e) and 423.184(e) provide authority and a mechanism for the removal of measures for specific reasons (low statistical reliability and when the clinical guidelines associated with the measure change such that the specifications are no longer believed to align with positive health outcomes). In the April 2019 final rule, CMS amended §§ 422.166(a)(2)(i) and 423.186(a)(2)(i) to update the methodology for calculating cut points for non-Consumer Assessment of Healthcare Providers and Systems (non-CAHPS) measures by adding mean resampling and guardrails, codified a policy to adjust Star Ratings for disasters, and finalized some measure updates. In the Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency Interim Final Rule (85 FR 19230; CMS–1744–IFC) published in the **Federal Register** website on April 6, 2020, CMS adopted a series of changes to the 2021 and 2022 Star Ratings to accommodate the disruption to data collection posed by the COVID–19 pandemic. Specifically, the IFC:

- Eliminates the requirement to collect and submit Healthcare Effectiveness Data and Information Set (HEDIS) and Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) data otherwise collected in 2020 and replaces the 2021 Star Ratings measures calculated based on those HEDIS and CAHPS data collections with earlier values from the 2020 Star Ratings (which are not

affected by the public health threats posed by COVID–19);

- Establishes how we will calculate or assign Star Ratings for 2021 in the event that CMS's functions become focused on only continued performance of essential agency functions and the agency and/or its contractors do not have the ability to calculate the 2021 Star Ratings;
- Modifies the current rules for the 2021 Star Ratings to replace any measure that has a systemic data quality issue for all plans due to the COVID–19 outbreak with the measure-level Star Ratings and scores from the 2020 Star Ratings;
- In the event that we are unable to complete Health Outcomes Survey (HOS) data collection in 2020 (for the 2022 Star Ratings), replaces the measures calculated based on HOS data collections with earlier values that are not affected by the public health threats posed by COVID–19 for the 2022 Star Ratings;
- Removes guardrails for the 2022 Star Ratings by delaying their application to the 2023 Star Ratings;
- Expands the existing hold harmless provision for the Part C and D Improvement measures to include all contracts for the 2022 Star Ratings; and
- Revises the definition of ''new MA plan'' so that for purposes of 2022 quality bonus payments based on 2021 Star Ratings only, new MA plan means an MA contract offered by a parent organization that has not had another MA contract in the previous 4 years, in order to address how the 2021 Star Ratings will be based in part on data for the 2018 performance period.

Please see the IFC for further information on these changes for the 2021 and 2022 Star Ratings.

In the February 2020 proposed rule, we proposed enhancements to further increase the stability of cut points by modifying the cut point methodology for non-CAHPS measures through direct removal of outliers. We also proposed to increase the weight of patient experience/complaints measures and access measures and remove the Rheumatoid Arthritis Management (Part C) measure from the Star Ratings because the measure steward is retiring the measure from the HEDIS measurement set. We proposed to modify the classification of the Statin Use in Persons with Diabetes (SUPD) measure from an intermediate outcome measure to a process measure, starting with the 2023 Star Ratings, due to feedback in response to the Draft 2020 Call Letter and to align with the measure steward's clarification regarding the measure's classification. In addition, we proposed other policies to amend the Part C and Part D Star Ratings but are not addressing those proposals in this final rule; those other proposals will be addressed in a future final rule.

Our proposal was for the changes we address here—the removal of outliers, increasing the weight of certain classes of measures, removing the Rheumatoid Arthritis Management measure, and reclassifying the SUPD measure—to be effective for the 2021 performance period and the 2023 Star Ratings. As discussed in this section, we are finalizing the proposed changes with some modifications. As finalized, the change to the weight of the patient experience/complaints measures and access measures, the removal of the Rheumatoid Arthritis Management measure, and the reclassification of the SUPD measure are applicable (that is, data would be collected and performance measured) for the 2021 measurement period and the 2023 Star Ratings. Under this final rule the direct removal of outliers will apply for the 2022 measurement period and the 2024 Star Ratings.

CMS appreciates the feedback we received on our proposals. In the sections that follow, which are arranged by topic area, we summarize the comments we received on each proposal and provide our responses. Below we summarize some general comments we received about the potential impact of the COVID–19 public health emergency on our Star Ratings proposals.

Comment: Numerous commenters requested that CMS refrain from making any changes to the Star Ratings system until the COVID–19 pandemic's impact on the healthcare system is better understood. They suggested we delay any changes to the quality rating system until after the public health emergency resulting from COVID–19 subsides due to the significant uncertainties around the duration and impact of COVID–19 on the healthcare system.

Response: CMS agrees that there is a lot of uncertainty about how COVID–19 will impact the healthcare system. However, we still believe that it is important to move forward with some limited Star Ratings changes to further emphasize the importance of patient experience/complaints measures and access measures and to help stabilize the movement in the cut points from year to year. The changes to the weighting of patient experience/complaints measures and access measures apply to the 2021 measurement year, not the 2020 measurement year when the pandemic first started. The implementation of Tukey outlier deletion has been delayed an additional year. Although there is some uncertainty how COVID–19 will impact the healthcare system and quality measurement, plans will have until the 2021 measurement year to adjust their processes to account for the impact of COVID–19 on Star Ratings measures.

Comment: Commenters raised concerns that additional Star Ratings changes may be needed to account for COVID–19 in future years. For example, several commenters noted data collection challenges could impact 2021, 2022, 2023, and 2024 Star Ratings for some measures. A commenter noted COVID–19 may overwhelm our healthcare systems leading to significant impacts on many measures. A few commenters specifically noted concerns about supply chain disruptions and prescription drug shortages. A commenter noted that plan activities in response to emergency situations can create unintended consequences in the years following, including for Star Ratings. Another commenter suggested CMS revisit the capacity and capability expectations defined in specific measures and meet with provider and plan stakeholders when the crisis has abated; they suggest some measures may need to be re-tooled so that scarce resources are devoted to building capacity and functionality of the health and social delivery systems.

Response: CMS is continuing to monitor the situation to see if additional Star Ratings changes are necessary and appropriate. As noted above, the IFC includes a series of changes for the 2021 and 2022 Star Ratings to accommodate challenges arising from the COVID–19 pandemic. Please see the IFC for further information on these changes for the 2021 and 2022 Star Ratings. CMS recognizes that there may be impacts from COVID–19 on measure scores and is delaying the implementation of Tukey outlier deletion for an additional year to allow these impacts to play out before adding an additional methodological change for the cut point calculations.

Comment: A commenter asked that CMS remain cautious on pursuing changes that could weaken the ability of plans to make quality improvements in the aftermath of COVID–19.

Response: CMS recognizes the challenges that COVID–19 has placed on the healthcare system and Part C and Part D plans that are subject to the Quality Star Rating System. CMS continues to monitor whether additional Star Ratings adjustments are necessary and appropriate.

Comment: A commenter requested that CMS ensure that policy changes that allow pharmacies to meet prescription drug therapy needs during the COVID–19 outbreak are not used to penalize pharmacies in their performance ratings.

Response: CMS will continue to monitor the impact of COVID–19 on the healthcare system. The Part C and D Star Ratings are for rating the Medicare health and drug plans not pharmacies.

Comment: Several commenters noted that different areas of the country may experience the pandemic differently, and there may also be differences by health plan populations, such as those with high dual eligible or low-income populations. A commenter noted that CDC's recommendation for social distancing, especially for more vulnerable populations, may result in Medicare beneficiaries not pursuing preventive screenings, and that this may be more impactful for beneficiaries in geographies more heavily impacted by COVID–19 and for beneficiaries in rural areas with less access to care.

Response: CMS will continue to monitor the impact of COVID–19 on the healthcare system and Part C and D plans. The IFC addressed the immediate impact of the pandemic on the Part C and D Star Ratings program and made additional modifications for the 2022 Star Ratings, in recognition that the COVID–19 pandemic may impact performance on the Star Ratings measures during the 2020 measurement period. CMS delayed the implementation of guardrails to allow cut points to adjust to changes in industry performance for the 2020 measurement period. Additionally, CMS expanded the hold harmless provisions for the Part C and D improvement measures that are based on the 2020 measurement period so that those measures where there is a significant decrease in performance will not bring down a contract's overall or summary ratings for the 2022 Star Ratings. CMS continues to monitor to what extent our current policy for extreme and uncontrollable circumstances codified at §§ 422.166(i) and 423.186(i) will help address the issue of some geographic areas being more impacted than others and whether additional Star Ratings adjustments are necessary and appropriate.

Comment: A commenter asked that CMS consider the longer-term economic ramifications that COVID–19 is causing to highly impacted areas when considering Star Ratings policies.

Response: CMS will continue to monitor the impact of COVID–19 on the healthcare system and Part C and Part D plans that are subject to the Quality Star Rating System. CMS continues to monitor whether additional Star Ratings adjustments are necessary and appropriate.

Comment: A commenter suggested that given the strain COVID–19 is placing on the healthcare system, CMS should suspend Effectiveness of Care measures based on 2020 data. Another asked whether the Part D appeals measures would still be removed for 2021.

Response: Generally, these comments are out of the scope of the proposed rule and the policies we are addressing in this final rule. The IFC addressed the immediate implications of the pandemic on the Part C and D Star Ratings program. Specifically, for the 2020 measurement year, it delays the implementation of guardrails so cut points will adjust downward if industry performance broadly declines as a result of the pandemic. CMS is proceeding to remove the Part D appeals measures for the 2020 measurement year and the associated 2022 Star Ratings, as outlined in the 2020 final Call Letter, under § 423.184(e)(1) and based on our determination that the measure is no longer reliable.

Comment: Several commenters gave specific feedback related to the IFC and the 2021 and 2022 Star Ratings.

Response: We thank commenters for this feedback, but these comments are out of scope for this rule. We will discuss comments to the IFC policies in a future final rule.

2. Measure-Level Star Ratings (§§ 422.166(a), 423.186(a))

Over the past 2 years, we have codified and refined the methodology for calculating the Star Ratings from the performance scores for non-CAHPS measures. At §§ 422.166(a) and 423.186(a), we initially codified the historical methodology for calculating Star Ratings at the measure level in the April 2018 final rule. The methodology for non-CAHPS measures employs a hierarchical clustering algorithm to identify the gaps that exist within the distribution of the measure-specific scores to create groups (clusters) that are then used to identify the cut points. The Star Ratings categories are designed such that the scores in the same Star Ratings category are as similar as possible and the scores in different Star Ratings categories are as different as possible. The current methodology uses only data from the most recent Star Ratings year; therefore, the cut points are sensitive to changes in performance from 1 year to the next.

The primary goal of any cut point methodology is to disaggregate the distribution of scores into discrete categories or groups such that each grouping accurately reflects true performance. The current MA Star Ratings methodology converts measure-specific scores to measure-level Star Ratings so as to categorize the most similar scores within the same measure-level Star Rating while maximizing the differences across measure-level Star Ratings. We solicited comments in the Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program Proposed Rule (hereinafter referred to as the November 2017 proposed rule) regarding the approach to convert non-CAHPS measure scores to measure-level Star Ratings (82 FR 56397 through 56399). We requested input on the desirable attributes of cut points and recommendations to achieve the suggested characteristics in the Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Benefit, Programs for All-inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021 Proposed Rule (hereinafter referred to as the November 2018 proposed rule). In addition, we requested that commenters either suggest alternative cut point methodologies or provide feedback on several options detailed in the November 2018 proposed rule, such as setting the cut points by using a moving average, using the mean of the 2 or 3 most recent years of data, or restricting the size of the change in the cut points from 1 year to the next.

The commenters identified several desirable attributes for cut points that included stability, predictability, and attenuation of the influence of outliers; commenters also suggested restricting movement of cut points from one year to the next and recommended that CMS either pre-announce cut points before the plan preview period or pre-determine cut points before the start of the measurement period. In the April 2018 final rule (83 FR 16567), we expressed appreciation for our stakeholders' feedback and stated our intent to use it to guide the development of an enhanced methodology while maintaining the intent of the cut point methodology to accurately reflect true performance.

Using the feedback from the comments we received in response to

the November 2018 proposed rule, we considered enhancements to the methodology that would increase the stability and predictability of the cut points and finalized in the April 2019 final rule two enhancements to the historical methodology. In the April 2019 final rule, we amended §§ 422.166(a)(2)(i) and 423.186(a)(2)(i) to add mean resampling of the current year's data to the current clustering algorithm to attenuate the effect of outliers; we also added measure-specific caps in both directions to provide guardrails so that the measure-threshold-specific cut points do not increase or decrease more than the cap from one year to the next. The IFC (CMS–1744–IFC) delays the implementation of guardrails for an additional year; thus, it will be implemented for the 2021 measurement year and the 2023 Star Ratings.

Some commenters to the November 2018 proposed rule believed mean resampling would not be sufficient to address outliers and expressed support for directly removing outliers before clustering. We did not finalize an approach for directly removing outliers in the April 2019 final rule in order to provide the public prior notice of a proposal for incorporating removal of outliers and an opportunity to comment on a specific approach and so that we could continue to evaluate the methodologies for outlier removal (84 FR 15761).

As we stated in the April 2019 final rule in response to public comments on this topic, we evaluated two options to address direct removal of outliers—trimming and Tukey outer fence outlier deletion. Under trimming, all contracts with scores below the 1st percentile or above the 99th percentile are removed prior to clustering. Although trimming is a simple way to remove extreme values, it removes scores below the 1st percentile or above the 99th percentile regardless of whether such scores are true outliers. This means in cases when true outliers are between the 1st and 99th percentile, they would not be removed by trimming, and in cases when the distribution of scores is skewed, scores that are not true outliers would be trimmed.

In the February 2020 proposed rule, we proposed to use Tukey outer fence outlier deletion as the method to identify and delete outliers before applying the already-applicable mean resampling and hierarchical clustering processes. With mean resampling, measure-specific scores for the current year's Star Ratings are randomly separated into 10 equal-sized groups. The hierarchical clustering algorithm is done 10 times, each time leaving one of the 10 groups out. The method results in 10 sets of measure-specific cut points. The mean cut point for each threshold per measure is calculated using the 10 values. Tukey outer fence outlier deletion is a standard statistical method. Tukey outer fence outliers are sometimes called Whisker outliers. Under this methodology, outliers are defined as measure scores below a certain point or above a certain point. We proposed that the lower point or the ''lower outer fence'' would be identified with this formula: (first quartile − 3.0 × (third quartile − first quartile)); and the higher point or the ''upper outer fence'' would be identified with this formula: (third quartile + 3.0 × (third quartile − first quartile)). The Tukey outer fence outlier deletion will remove all outliers based on the previous definition for the two points (that is, the lower and upper outer fences) and does not remove any cases that are not identified as outliers. Values identified as outside the Tukey outer fences would then be removed immediately prior to clustering.

We explained in the proposed rule that if Tukey outer fence outlier deletion and a 5 percent guardrail had been implemented for the 2018 Star Ratings, 2 percent of MA–PD contracts would have seen their Star Rating increase by half a star, 16 percent would have decreased by half a star, and one contract would have decreased by 1 star. For PDP contracts, 2 percent would have increased by half a star, and 18 percent would have decreased by half a star. This simulation of the impact of Tukey outlier deletion also takes into account the removal of the two Part D appeals measures (Appeals Auto-Forward and Appeals Upheld) and the Part C measure Adult BMI Assessment, because these measures will be removed starting with the 2022 Star Ratings. In general, there tends to be more outliers on the lower end of measure scores. As a result, the 1 to 2 star thresholds often increased in the simulations when outliers were removed compared to the other thresholds which were not as impacted.

We requested comments on our proposal to use Tukey outer fence outlier deletion as an additional step prior to hierarchal clustering. We explained that under our proposal in the first year of implementing this process, the prior year's thresholds would be rerun, including mean resampling and Tukey outer fence deletion so that the guardrails would be applied such that there is consistency between the years. We proposed to amend §§ 422.162 and 423.182 to add a definition of the outlier methodology (''Tukey outer fence outliers'') and to amend §§ 422.166(a)(2)(i) and 423.186(a)(2)(i) to apply the outlier deletion using that methodology prior to applying mean resampling with hierarchal clustering.

We received the following comments related to our proposal, and our responses follow:

Comment: Most commenters opposed moving forward with the Tukey outlier deletion at this time, citing a variety of different reasons. A handful of commenters raised general concerns about the Tukey outlier deletion method, mentioning criticism in academic communities about applying Tukey fences to skewed data, given what the commenters characterized as the Tukey approach's assumption of a normal distribution. Other commenters suggested additional research is needed on alternatives for removing outliers. Some commenters did not support the use of Tukey outlier deletion without more information about how the Tukey outlier fence models will be applied and more detail on CMS analyses. A couple of commenters did not support adding Tukey outlier deletion given the fluctuation it may cause in the ratings.

Response: CMS is concerned about extreme outliers influencing cut point determinations and has selected an approach to identify and remove outliers prior to clustering contract scores to determine cut points for assigning measure stars. The main objective of removing outliers is to stabilize cut points and prevent large year-to-year fluctuations in cut points caused by the scores of a few contracts. CMS selected the conservative outer-fence form of the Tukey outlier deletion method because it is transparent (easily understood and can be implemented by stakeholders with widely-available software) and robust to distributional shape (it performs as intended for this purpose across the range of score distributions seen in Star Ratings data).

CMS disagrees that the Tukey outer fence outlier approach is inappropriate for identifying the outliers to be removed from the performance score data. Even when the data are not normally distributed (for example, in a skewed distribution), the Tukey approach performs as intended. The Tukey outer fence outlier deletion approach is a standard statistical method that is non-parametric, that is, it is not dependent on distributional assumptions. We plan to adopt a more conservative definition, based on Tukey *outer* fences, that only removes scores that are extreme outliers. This approach removes fewer outliers at both extremes of the score distribution than the inner

fence approach. We plan to identify and remove extreme outliers immediately prior to applying the clustering algorithm to set cut points. The Tukey outer fences would be calculated from the set of measure scores after removing contracts that are to be excluded from clustering (such as because the measure is voluntary for that contract).

The first step in applying the Tukey outlier deletion method is calculating the first quartile (Q1) and third quartile (Q3) of the score distribution: 25 percent of scores fall below Q1, another 25 percent of scores fall above Q3, and the remaining 50 percent of scores fall between Q1 and Q3. Next, we calculate the interquartile range (IQR), the difference between the third and first quartiles (IQR = Q3 − Q1), which refers to the range of the middle 50 percent of all scores. The Tukey outer fence method identifies extreme outlier as those that are below (Q1 $-3 \times$ IQR) or above (Q3 + $3 \times$ IQR).

We examined the use of trimming as an alternative outlier removal approach and found very similar results as those described in the proposed rule from using the Tukey approach. We performed simulations that trimmed any scores that were above the 99th percentile or below the 1st percentile, trimming values at the tail ends of the distribution prior to clustering. The method had effects on Star Ratings similar to those of the Tukey method. An important strength of the Tukey outer fence outlier deletion method over the trimming method is that trimming removes a fixed proportion of plan scores for each measure, regardless of whether those scores are distant from the center of the score distribution. In contrast, the Tukey outer fence method removes only true outliers that are the most distant from the center of scores.

Comment: Some commenters suggested alternatives to outlier deletion to help improve the stability of cut points. A commenter suggested that CMS might consider cut points using plans in similar geographic areas with similar characteristics. Another suggested CMS explore other classification methods such as Isolation Forest, DBSCAN, or k-means clustering. A couple of commenters recommended a guardrail cap less than 5 percent.

Response: CMS agrees that stability is a goal for the cut points, but we disagree with the recommendations of the commenters to achieve that stability. Setting regional or geographic benchmarks (cut points) would lead to a 5-star contract in one area differing in terms of performance from a 5-star contract in another area. The Medicare program does not set regional standards, but rather applies a single national standard to evaluate plan performance. As required under section 1851(d), CMS disseminates information to Medicare beneficiaries (and prospective Medicare beneficiaries) on the different coverage options to promote an active, informed selection among such options. This includes plan quality and performance indicators to compare plan options. In order to compare in a consistent way, CMS uses a single national standard since different regional cut points could hide deficiencies in different areas. Additionally, many measures are based on compliance with Medicare rules and requirements (for example, call center measures and appeals measures) and reflect compliance with Medicare program requirements, not comparative compliance. Using regional cut points would warp the results and complicate our use of Star Ratings under §§ 422.504(a)(17), 422.510(a)(4)(ix), 423.505(a)(26), and 423.509(a)(4)(x).

Regarding the choice of clustering method, hierarchical clustering is one of the most commonly used methods for clustering observations into groups. There are pros and cons of all methods for clustering, including those identified by the commenters. We have considered other methods and believe hierarchical clustering is the best option for the Part C and D Star Ratings program because it is well understood, easily implemented, and performs well for a variety of different data distributions. The other very commonly used clustering algorithm is k-means, however one key weakness of that approach is that the final set of clusters depends on the initial random assignment of points to clusters and it is highly sensitive to the initial placement of cluster centers. Specifically, when the algorithm is repeated on the same dataset it may result in different cluster assignments. Additionally, the k-means method is sensitive to outliers (for example, Gan and Ng (2017),[20] Govender and Sivakumar (2020) [21]), and therefore it would not resolve the issue that outliers can influence estimated thresholds. The commenter also noted other clustering algorithms that are less commonly used. For example, weaknesses of DBSCAN include sensitivity to parameters and inability to handle clusters of points of varying densities, which makes DBSCAN less attractive for clustering measure scores. Isolation Forest is an outlier or anomaly detection technique on the basis of decision trees that is not directly related to clustering measure scores into 5 groups.

Comment: A couple of commenters opposed Tukey outlier deletion since they were concerned it would make it harder for plans with more complex populations to perform well, including SNP plans. A commenter noted the current national emergency emphasizes the need for the cut point methodology to separate out plans with high proportions of dually-eligible, disabled, and low-income individuals.

Response: The issues of whether it is harder for plans with complex populations to perform well in Star Ratings and the method by which we stabilize thresholds for cut points are unrelated. The strategy of removing outliers for stability of cut points does not affect how performance is compared across plans with and without complex populations.

In simulations of Star Ratings calculated using the Tukey outer fence outlier approach, we found that the effect of outlier removal on SNP versus non-SNP contracts was not very different. When outlier measure scores were removed as a part of our simulation using the data for the 2018 Star Ratings, overall summary ratings shifted from 4 to 3.5 stars for approximately 4 percent of contracts without a SNP, and for about 5 percent of contracts with a SNP for the contracts with overall ratings. The removal of outliers will not necessarily have consistent year-to-year impacts, and is dependent on where contracts fall in the measure score distributions, with contracts near the bottom of a score range being the most likely affected.

CMS adopted the categorical adjustment index (CAI) to address the concern that plans with more complex populations have lower ratings based on the population served under the contract. The CAI advances more equitable plan comparisons because it generates Star Ratings that contracts would have received if they had all served the same patient population. That is, the CAI adjusts for within-contract disparities based on measures that are not otherwise adjusted for patient characteristics. CAI coefficients are estimated each year so if there is a differential impact of COVID–19 on the measures of performance for contracts with a higher percentage of dual eligible and disabled beneficiaries versus contracts with a lower percentage of enrollees with those social risk factors, the CAI values would reflect these

[20] Gan, G., & Ng, M.K. (2017). K-means Clustering with Outlier Removal. *Pattern Recognit. Lett., 90,* 8–14.

[21] Govender, P. & Sivakumar, V. (2020). Application of k-means and hierarchical clustering techniques for analysis of air pollution: A review (1980–2019). Atmospheric Pollution Research. 11(1), 40–56.

differences. The CAI will continue to adjust for the percentage of LIS/DE and disabled beneficiaries within the contract in accordance with §§ 422.166(f)(2) and 423.186(f)(2), and therefore will adjust for these differences for contracts with and without a SNP.

Comment: A commenter suggested that CMS retire measures from the program when there are one percentage point differences in the same direction between cut points year over year.

Response: CMS does not consider the size of changes in performance from year-to-year to be a criterion for retirement of a measure, particularly when there is still room for improvement on the measure. CMS retires or removes measures from Star Ratings when there is a change in clinical guidelines that mean that the measure specification is no longer believed to align with or promote positive health outcomes and when measures show low statistical reliability. These standards are in §§ 422.164(e)(1) and 423.184(e)(1), and we explained how we interpret and apply the standards in the April 2018 final rule. When measure scores are ''topped out'' (that is, show high performance across all contracts), this decreases the variability across contracts and makes the measure unreliable. On average, measures improve year-to-year in the 1 to 3 percentage point range, with the exception of new measures where the performance generally has more substantial room for improvement or in situations where a structural change occurs (for example, implementation of EHR tools) that significantly alter performance on the measure.

Comment: A couple of commenters suggested convening a Technical Expert Panel (TEP) to provide input into the Tukey outlier deletion.

Response: A TEP comprised of representatives across various stakeholder groups convened on May 31, 2018 to provide feedback to the RAND Corporation, the current CMS contractor for the Part C and D Star Ratings program to obtain input on a number of issues, including increasing the stability of cut points (*https://www.rand.org/pubs/conf_proceedings/CF391.html*). This TEP focused on different ways to increase stability of cut points, including outlier deletion, but did not focus on the different methods for deleting outliers. We do not believe another TEP is necessary to specifically address this topic given the RAND TEP already expressed strong support for directly addressing outliers and this methodology for removing outliers is a widely accepted methodology for removing outliers.

Comment: A handful of commenters wanted to see the impact on their individual plans to be able to fully understand the effect of Tukey outlier deletion.

Response: CMS plans to display simulations of Tukey outlier deletion with mean resampling and guardrails for contracts to view in HPMS for the 2021, 2022, and 2023 Star Ratings prior to implementing the Tukey outlier change effective with the 2024 Star Ratings. These simulations will use the actual data that will be populating the 2021, 2022 and 2023 Star Ratings and will include all of the changes finalized related to cut point calculations. As noted in the NPRM, for the first year (2024 Star Ratings), we will rerun the prior year's thresholds, using mean resampling and Tukey outer fence deletion so that the guardrails would be applied such that there is consistency between the years. This, therefore, will be done for the simulations using the 2021 Star Ratings. This will provide information for multiple years for plans to see how the cumulative impact of the changes will impact the cut points going forward. Please note that currently mean resampling will be implemented with the 2022 Star Ratings, guardrails will be added with the 2023 Star Ratings, and Tukey outlier deletion will be implemented with the 2024 Star Ratings. Our planned simulations will illustrate the cumulative effect of all of these policies.

Comment: A commenter said CMS could further address outliers by removing contracts that are not eligible for Quality Bonus Payments such as 1876 cost plans and Medicare-Medicaid Plans.

Response: CMS does not include Medicare-Medicaid Plans in the calculation of cut points for the Part C and D Star Ratings since they currently do not receive Star Ratings on Medicare Plan Finder; however, although not eligible for bonuses, 1876 cost plans are part of the Part C and D Star Ratings program (see § 417.472(k)) and have historically received Star Ratings on Medicare Plan Finder so these contracts are included in the cut point calculations. Otherwise, the ratings for public reporting would not be comparable for beneficiaries to use in evaluating their coverage choices.

Comment: A commenter asked for clarification about whether measures in the program for three or fewer years would be included in the Tukey outlier deletion.

Response: We are finalizing the proposed amendment to apply Tukey outlier deletion to all non-CAHPS measures, beginning with the 2024 Star Ratings. This application will be for all such measures regardless of the number of years the specific measure has been used in the Star Ratings program.

Comment: A number of commenters suggested publishing cut points in advance of the measurement year by relying on the data from earlier time periods, reinstituting pre-determined 4-star thresholds, or designing cut points that establish clear national standards of care. Some of the commenters noted that announcing cut points prior to the measurement period would help plans and providers engage in value-based contracts that incentivize higher quality.

Response: CMS understands the interest in setting pre-determined cut points prior to the measurement year, but as stated previously in the April 2019 final rule (84 FR 15752–15754) there are numerous challenges in setting pre-determined cut points, including older data not being reflective of current performance, average performance not always increasing in a linear manner, external factors resulting in significant changes in performance from year to year, larger gains in performance generally seen for newer measures, and the rate of change differing for low performing contracts compared to higher performing ones. Additionally, the measures included in the Star Ratings program do not have national standards of care that plans or providers should meet; thus, it would be challenging to come to consensus on national standards to rate plans in the Star Ratings program. If using older data to predict or establish cut points, we risk causing unintended consequences such as disincentivizing quality improvement or setting cut points that are not aligned to significant changes in industry performance. For example, no one could have predicted the significant impacts the COVID–19 pandemic would have on industry performance for various Star Ratings measures. The current methodology of hierarchal clustering using the current year's data will adjust cut points for the unforeseen impact on plan performance across the program. Since the clustering methodology compares relative performance, it protects plans from unanticipated impacts on industry performance. If there were pre-determined thresholds based on historical data or an independent standard, plans could end up all with uniformly low ratings when unanticipated situations such as the COVID–19 pandemic occur.

Comment: A number of commenters recommended including outliers in the

cut point calculations since they represent the true performance of contracts on the measures. Commenters stated that without including these outliers, CMS would not fully be representing industry performance. Other commenters noted that with the current data integrity polices in place for the Star Ratings program, these outliers are legitimate measure-level contract scores.

Response: CMS agrees that an outlier may be a legitimate score for a particular contract, but we also know that extreme outliers for a measure in a given year can impact statistical analyses such as clustering. In the April 2019 final rule (84 FR 15755–15758) we received stakeholder feedback that in addition to guardrails and mean resampling we should directly address the impact of outliers. Although mean resampling does not directly address outliers, it helps mitigate the effect of outliers because when establishing the thresholds each data point (including outliers) is omitted from 10 percent of the cut points that are estimated (cut points are repeatedly estimated on ten subsets each containing 90 percent of the measure scores) and then averaged across the ten 90 percent samples following resampling. However, based on feedback from the industry to further increase the stability of the cut points and to prevent large fluctuations in cut points from one year to the next caused by the scores of a few contracts, we proposed in the February 2020 proposed rule to more directly remove extreme outliers and are finalizing that policy.

Comment: A handful of commenters supported the addition of Tukey outlier deletion to the cut point methodology, while some suggested delaying implementation or viewing Tukey outlier deletion as an interim solution to improving the stability of the cut points. A commenter suggested phasing in outlier deletion over a multi-year period by putting the cut points with Tukey outlier deletion on display for two years.

Response: We appreciate the support for the addition of Tukey outlier deletion to the cut point methodology and have decided to delay the implementation for an additional year recognizing that there may be fluctuations in measure-level scores as a result of the COVID–19 pandemic. We will also display simulations for the 2021, 2022, and 2023 Star Ratings in HPMS for contracts to see the impact of removing outliers on their stars.

Summary of Regulatory Changes

After consideration of the comments and for the reasons indicated in the proposed rule and our responses to the related comments, we are finalizing as proposed the definition ''Tukey outer fence outliers'' and the specific formulae used. We are finalizing revisions to §§ 422.166(a)(2)(i) and 423.186(a)(2)(i) to apply the Tukey outlier deletion methodology prior to applying mean resampling with hierarchal clustering as proposed with one modification. To allow for potential fluctuations in measure-level scores as a result of the COVID–19 pandemic during the 2021 measurement year, we are delaying the addition of Tukey outer fence outlier deletion to the clustering methodology for non-CAHPS measures until the 2022 measurement year and the corresponding 2024 Star Ratings. Moving the effective date will provide an opportunity for MA and Part D contracts to view simulated results using Tukey outlier deletion for the 2021, 2022, and 2023 Star Ratings in HPMS. We note that the regulation text in this final rule incorporates the changes made by the IFC to §§ 422.166(a)(2)(i) and 423.186(a)(2)(i) during the period between the proposed rule and this final rule. The effect of Tukey outlier deletion would create a savings of $935 million for 2025, increasing to $1,449.2 million by 2030.

3. Removing Measures (§§ 422.164, 423.184)

The regulations at §§ 422.164 and 423.184 specify the criteria and procedure for adding, updating, and removing measures for the Star Ratings program. Due to the regular updates and revisions made to measures, CMS does not codify a list in regulation text of the measures (and specifications) adopted through rulemaking for the MA and Part D Star Ratings Program (83 FR 16537). CMS lists the measures used for the Star Ratings each year in the Technical Notes or similar guidance document with publication of the Star Ratings. In the February 2020 proposed rule, CMS proposed the removal of the Rheumatoid Arthritis Management measure from the Star Ratings program for performance periods beginning on or after January 1, 2021.

CMS proposed to remove the Rheumatoid Arthritis Management measure from the Part C Star Ratings for the 2021 measurement year and the 2023 Star Ratings. The measure steward, NCQA, is retiring this measure from the HEDIS measurement set for the 2021 measurement year due to multiple concerns. For example, there are concerns that the performance on the measure may not reflect the rate at which members get anti-rheumatic drug therapy because sometimes these medications are covered by Patient Assistance Programs, which do not generate claims. In terms of the measure construction, the measure assesses only if members received a disease-modifying anti-rheumatic drug once during the measurement year, rather than assessing if members remain adherent to the medication. Additionally, it is unclear, based on the evidence, whether patients in remission should remain on these medications. Since NCQA plans to retire this measure from the HEDIS measurement set, CMS proposed to remove it starting with the 2023 Star Ratings.

Below we summarize the comments we received and provide our responses and final decisions.

Comment: Most commenters supported the retirement of the Rheumatoid Arthritis Management measure and offered a number of reasons for their support. Approximately half of the commenters who supported removal believed current measure specifications erroneously include certain patients in the measure denominator: Those receiving medication through clinical trials, patient assistance programs, or other ways of paying; patients in remission or managing their illness with other drugs; and patients who have side effects or cannot tolerate disease-modifying anti-rheumatics drugs (DMARDS). A couple of commenters noted that the rate of medication adherence would be a better measure of patient outcomes than the current focus on DMARD dispensing. Individual commenters raised a number of additional issues with the measure: The role of the rheumatologist is not captured by the current measure; the measure has low reliability; there is no clinical consensus on whether patients in remission should remain on DMARD medications or should stop taking them at some point; removal of the measure will streamline ratings systems since NCQA has retired the measure from HEDIS; and continued use of the measure would promote unnecessary use of DMARDS.

Response: CMS will pass along to the measure developer suggestions made by commenters for additional research and new directions. NCQA has retired this measure and therefore there will be no data for CMS to use in the Star Ratings program for the 2023 Star Ratings and beyond, so CMS will remove the measure from the Parts C and D Star Ratings.

Comment: A couple of commenters disagreed with CMS's proposal and offered similar explanations and recommended actions for CMS to take

instead of removing the measure. The commenters note that there is room for improvement in the measure in some populations and in some regions. They also note that research is only beginning into the long-term outcomes of patients recovering without use of DMARDS. For these reasons, they suggest it is premature to update the specifications of the measure or to retire the measure. Instead, they suggest additional research into the long-term outcomes and functional status of patients recovering without use of DMARDS.

Response: CMS will pass along the suggestions for future research to the measure developer, NCQA. NCQA has retired this measure starting with the 2021 measurement year, so starting in 2021 this measure will no longer be submitted by plans and audited as part of the HEDIS measurement set. Thus, there will be no data for CMS to use in the Star Ratings program for the 2023 Star Ratings and beyond. Additionally, CMS agrees with NCQA's assessment of the need to retire this measure at this time.

Summary of Regulatory Changes

After consideration of the comments and for the reasons set forth in the proposed rule and our responses to the related comments summarized earlier, we are finalizing the removal of the Rheumatoid Arthritis Management measure.

4. Measure Weights (§§ 422.166(e), 423.186(e))

As finalized in the April 2018 final rule, beginning with the 2021 Star Ratings, §§ 422.166(e)(1)(iii) and (iv) and 423.186(e)(1)(iii) and (iv) provide that the weight for patient experience/complaints measures and access measures will increase to 2. We stated in the April 2018 final rule (83 FR 16575–16576) that given the importance of hearing the voice of patients when evaluating the quality of care provided, CMS intends to further increase the weight of patient experience/complaints measures and access measures in the future. The measures include the patient experience of care measures collected through the CAHPS survey, Members Choosing to Leave the Plan, Appeals, Call Center, and Complaints measures. We stated the majority of the measures impacted by the proposed weight change are the CAHPS measures that focus on critical aspects of care from the perspective of patients such as access and care coordination issues. The experience of care measures focus on matters that patients themselves say are important to them and for which they are the best or only source of information.

We explained the proposed increase in the weight would not impact the assignment of stars at the measure level, just the calculation of the overall and summary ratings, and would not impact the distribution of stars which varies for each of these measures. The statistical reliability of the CAHPS measures is high, exceeding standards for quality measurement so that higher star categories correspond to meaningfully better performance (generally, reliabilities of 0.7 or more are considered high for a quality measure [22]). The inter-unit reliability of the CAHPS measures range from 0.7638 for Customer Service to 0.9215 for Rating of Health Plan measure. The reliability for the other measures is as follows: Care Coordination is 0.8155, Getting Appointments and Care Quickly is 0.9059, Getting Needed Care is 0.8543, Getting Needed Prescription Drugs is 0.7895, Rating of Drug Plan is 0.8937, and Rating of Health Care Quality is 0.8263.

CMS has pledged to put patients first and to empower patients to work with their providers to make health care decisions that are best for them. To best meet the needs of beneficiaries, CMS believes we must listen to their perceptions of care, as well as ensure that they have access to needed care. Thus, CMS proposed to modify §§ 422.166(e) and 423.186(e) at paragraphs (e)(1)(iii) and (iv) to increase the weight of patient experience/complaints measures and access measures to 4 to further emphasize the importance of patient experience/complaints and access issues.

We received the following comments related to our proposal, and our responses follow:

Comment: The majority of commenters opposed the weight increase of patient experience/complaints and access measures from 2 to 4. Most of these commenters argued that CMS should not value patient experience over clinical outcomes (currently weighted as 3) as they believe clinical outcome measures are the most important. Because some plans may not have enough enrollees to report all of the outcome measures included in the Star Ratings program, some commenters argue the proposed weighting changes would create an even greater imbalance between the total weight given to patient experience measures versus clinical outcome measures for these plans. A commenter stated that since the intended purpose of the Star Ratings program is to compare plan performance on measures related to beneficiary health outcomes and experience, the increase has the potential to erode the integrity of the Star Ratings program by basing the majority of the Star Rating score on patient experience and complaints measures instead of clinical outcomes.

Response: CMS appreciates the value commenters place on outcome measures and will continue to advance work in the area of developing new outcome measures. That being said, it is important to make sure the voice of patients is heard and that patient experience is a key component of the overall and summary Star Ratings. Part of putting patients first and promoting patient-centered care is focusing on patients' perspectives. Additionally, for those plans that may not have enough enrollees to report all of the outcome measures included in the Star Ratings program, we believe that this increased weighting of experience measures would provide such plans an opportunity to focus on improving patient experience and differentiate themselves in the market as a plan that anticipates members' needs and works with enrollees in a customized way. Consequently, we are emphasizing CMS's goal of listening to the voice of the patient to identify opportunities to improve care delivery. Under 1851(d) of the Act, CMS must provide information to promote an active, informed selection among plans, and hearing the perspective of beneficiaries is critical to understanding the differences among options. Weighting these measures higher will accomplish this goal.

Comment: A number of commenters argued that by increasing the patient experience/complaints measures and access measures from a weight of 2 to 4, CMS will be downplaying the importance of the provision of high quality clinical care. Some commenters also noted that this would not align with other CMS quality measurement programs, such as the Health Insurance Exchanges Quality Rating System (QRS), the underlying goals of the Part C and D Star Ratings program and non-Medicare quality improvement efforts, or with CMS's guiding principles for the Star Ratings program. A commenter noted that this contradicts the U.S. Department of Health and Human Services' (HHS') efforts as part of the Quality Summit to align federal healthcare quality rating programs. A commenter noted that the proposal also runs counter to the quality measurement principles of MedPAC, which establish the importance of outcome measures.

[22] *https://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR653.pdf.*

Response: The proposed increase in weight for patient experience/complaints measures and access measures is a new direction for the Part C and D Star Ratings program to advance the agency's goal of putting patients first and listening to their voice. While this direction differs from current policies in other quality programs, it is part of the agency's effort to strive to ensure we are meeting the needs of our beneficiaries by listening to their feedback through the CAHPS survey measures, disenrollment rates, and complaints measures. A primary function of Medicare health and drug plans is the provision of health care and drug services to beneficiaries. Measuring, and highly weighting, the importance of access to these services greatly encourage the industry to focus on their fundamental functions. Without access to care and needed prescription medications, optimal clinical outcomes are not probable. CMS believes access to services, care coordination, and patient engagement are intrinsic to positive clinical outcomes. A beneficiary's confidence in the health and drug plan helps facilitate continuation of care which could lead to better clinical outcomes. We agree with MedPAC's recommendation that population-based outcome and patient experience measures are critical in evaluating MA quality.

Comment: Commenters also raised concerns that this would take focus away from physician care and the clinical measures collected through HEDIS. Other commenters noted that the overwhelming emphasis on patient experience could have the unintended consequence of MA plans and providers not focusing on preventive screenings, such as colorectal cancer screening, which can save lives.

Response: Plans and providers should continue to focus on preventive care, screenings, and physician care. This weight change puts more emphasis on the voice of the beneficiary and access issues. We disagree with the characterization that this emphasis is overwhelming, and it in no way suggests that plans and providers should not be continuing to provide important preventive care and screenings. All MA and Part D sponsors are still required to have quality improvement (QI) programs described at §§ 422.152 and 423.153(c), respectively, in place. The primary goal of the MA organization's QI program is to effect sustained improvement in patient health outcomes. Additionally, by not continuing to focus on preventive screenings and primary care, this will have a detrimental effect on health outcomes and would have an impact on patient experience measure scores, disenrollment rates, and complaint rates, all measures included in the weight increase. Therefore, the risk of this particular negative outcome from the change in weighting the patient experience/complaints measures and access measures is minimized.

Comment: A number of commenters expressed concerns about what they perceive to be a fundamental, unprecedented shift away from the objective data-driven clinical Star Ratings measures to more subjective patient experience measures and encouraged a more thoughtful approach to ensure that the weight increase would not result in unintended consequences. Commenters raised issues regarding CMS creating incentives for plans and providers to provide care that would lead to increased CAHPS scores, and they argued this may not be in the best interest of Medicare beneficiaries and better health outcomes.

Response: Plans and providers should always be providing professional, appropriate clinical care to Medicare beneficiaries, thereby focusing broadly on quality, rather than on narrowly targeted metrics represented by individual Star Ratings measures. Patient experience is a fundamentally important aspect of healthcare quality. Most of the evidence shows that better patient experience is associated with better patient adherence to recommended treatment, better clinical processes, better hospital patient safety culture, better clinical outcomes, reduced unnecessary healthcare use, and fewer inpatient complications (Anhang Price et al., 2014; Anhang Price et al., 2015 [23]). The Anhang Price et al., 2014 article which consisted of a review of relevant literature related to CAHPS surveys and their relationship to health care quality found that all but one out of almost three dozen studies reviewed showed a positive correlation between patient experiences and clinical care quality or were neutral. The empirical evidence in the studies highlights that health care providers and plans can concurrently provide better patient experiences and better clinical quality. As discussed in the article, patient experience of care surveys such as the CAHPS surveys evaluate a critical component of care and focus on whether the care is patient-centered. This is an important goal as we continue to emphasize the importance of putting patients first.

Comment: A few commenters expressed concerns that this change would encourage plans to abandon efforts to drive clinically appropriate care in lieu of catering to popular opinion that may be biased by advertisements and media. Such behavior, it was noted, could result in degraded health outcomes long-term for Medicare beneficiaries. They argue programs that promote member health and safety, such as drug management and utilization programs, could be damaged or abandoned. A number of commenters stated that the improvement of health outcomes is one of the largest drivers of the long-term goal of reducing American health care costs and that shifting emphasis from clinical outcomes to member experience could lead to increased medical and pharmaceutical spending.

Response: Plans and providers should continue to focus on improving health outcomes, while also ensuring that Medicare beneficiaries have access to clinically appropriate and needed care, for example as measured through the CAHPS surveys, Appeals, Members Choosing to Leave the Plan, and Complaints measures. Outcome measures are still heavily weighted in the Star Ratings program with a weight of 3. We believe high quality care is meaningless unless the enrollee has access to that care. All MA and Part D sponsors are required to have quality improvement (QI) programs described at §§ 422.152 and 423.153(c), respectively, in place. The primary goal of the MA organization's QI program is to effect sustained improvement in patient health outcomes and providing health care using evidence-based clinical protocols. The QI program must also include a health information system to collect, analyze, and report Medicare Parts C and D quality performance data, including HEDIS, HOS, and CAHPS data. Additionally, as described at § 422.152(c), an MA organization's QI program must include a chronic care improvement program. Part D sponsors must also have established quality assurance measures and systems in place to reduce medication errors and adverse drug interactions and improve medication use. In addition to the requirements to focus on clinical-based care, MA and Part D plans, given their payment structures should have

[23] Anhang Price, R., Elliott, M.N., Zaslavsky, A.M., Hays, R.D., Lehrman, W.G., Rybowski, L., Edgman-Levitan, S. & Cleary, P.D. (2014). Examining the role of patient experience surveys in measuring health care quality. Medical Care Research and Review, 71(5), 522–554.

Anhang Price, R., Elliott, M.N., Cleary, P.D., Zaslavsky, A.M., & Hays, R.D. (2015). Should health care providers be accountable for patients' care experiences?. Journal of general internal medicine, 30(2), 253–256. *https://doi.org/10.1007/s11606-014-3111-7.*

incentives to decrease inappropriate medical and pharmaceutical spending.

Comment: Some commenters argued that if physicians do not proceed thoughtfully, patient experience measures could easily result in adverse consequences that are potentially dangerous to the patient. A commenter noted that if a person who is addicted to opioids seeks a prescription and the physician does not provide one, the patient could retaliate by leaving a negative review. It was suggested that in some cases physicians who overprescribe opioids may have very high reviews from patients, despite putting patients in real danger and contributing to the nation's opioid epidemic.

Response: The CAHPS survey questions are based on statistically valid samples of Medicare enrollees in each contract and should not be influenced by a particular physician providing opioids or not. They are not like crowd-sourced reviews. Most of the CAHPS survey questions focus on enrollees' experiences of care such as whether they got an appointment to see a specialist as soon as they needed, whether they got care as soon as they needed, whether the health plan's customer service gave them the information or help needed, and whether the doctor's office followed up on test results.[24] There are also global ratings of the health care quality, health plan, and drug plan. The change in measure weights does not suggest that any physicians behave in a manner that puts patients in danger, nor does it provide an excuse for a physician who does so.

Comment: A few commenters supported the increased weight of patient experience/complaints measures and access measures but only if the increase is gradual by moving it to a weight of 2.5 or 3 first to promote stabilization of the Star Ratings. It was noted that this proposal is a radical increase considering that CMS had maintained for eight consecutive Star Ratings cycles (2012–2019) the original weight of these measures (at a weight of 1.5). Commenters argued that when changes are made to an organization's culture, it can take years to see the improvements in patient experience scores since many beneficiaries interact with the health care system only a few times a year.

Response: We disagree that this is an unexpected and sudden change. The April 2018 final rule adopted an increase from 1.5 to 2 in the weight of patient experience and complaints measures and access measures. CMS signaled in that final rule that, given the importance of hearing the voice of patients when evaluating the quality of care provided, we intended to further increase the weight of these measures in the future. While we appreciate that organizations are being incentivized to quickly adjust to this weighting change, we believe it is important to proceed at this time, in particular, in light of the COVID–19 pandemic. The uncertainty from the pandemic is a critical time for plans to be focused on patient experience. Plans need to enhance patient experience to deal with the challenges of COVID–19 pandemic, to work with beneficiaries in customized ways, and be as supportive as possible. This is also an opportunity for them to distinguish themselves and be innovative in maintaining access to care. A goal of the Star Ratings program is to foster continuous improvement.

Comment: A handful of commenters opposed the weight increase for measures from the CAHPS survey. These commenters argued that the CAHPS survey measurement tool and methodology are outdated and need to be updated to accurately capture beneficiaries' perspectives of care since the private insurance market has significantly changed over time. Some commenters opposed the survey due to a variety of other reasons, including what they perceive as a lack of statistical reliability, small sample sizes, compression of cut points, differences in methodologies across CAHPS surveys and with the NCQA rating system, cut point variability, contract-level rating volatility, and lack of clinical relevance. A commenter stated that the measures are based on a limited sample that may yield inaccurate, unreliable, or biased data. A commenter stated that younger patients, those with disabilities, and members enrolled in a D–SNP are underrepresented in the survey. A couple of commenters stated that the CAHPS survey has no mechanism for health plans to identify and address negative experiences for a particular enrollee; therefore, these commenters encouraged CMS to release secure beneficiary-level CAHPS response data. A commenter said survey data should receive third-party validation.

Response: CAHPS measures focus on critical aspects of care from the perspective of patients such as access and care coordination issues. The experience of care measures focus on matters that patients themselves say are important to them and for which they are the best or only source of information. As a result of more than twenty years of research that is ongoing and leading to continuous improvement, CAHPS surveys are very good measures of patient experience. The CAHPS program, initiated in 1995, which includes the Medicare CAHPS Health Plan Surveys, seeks to advance the scientific understanding of patient experience with healthcare. Since then, CAHPS surveys have become recognized as the most widely validated, reliable, and applied patient experience surveys in the United States (Holt et al. 2019). Many articles documenting the reliability and face, content, and construct validity of the CAHPS surveys have been published (for example, Crofton, Lubalin, & Darby, 1999; Darby, Hays, & Kletke, 2005; Hays et al., 2014; Martino et al., 2009). In addition, many studies establish the validity of CAHPS measures by assessing their association with measures of structures, processes, and outcomes. For example, the 2014 review article (Anhang Price et al., 2014), in reviewing 34 studies, found that evidence indicated positive associations between patient experiences and other aspects or indicators of health care quality, including patient behavior (adherence), best practice clinical processes, better patient safety culture, and lower unnecessary utilization.[25]

The Medicare CAHPS survey is designed to capture changes in the insurance market that may adversely affect patient experience. The survey measures patient experience with care and captures whether enrollees in MA

[24] CAHPS composite items included in the Part C & D Star Ratings are: Getting Needed Care, Getting Appointments and Care Quickly, Customer Service, Care Coordination, and Getting Needed Prescription Drugs. All of these measures are considered patient experience of care measures.

[25] Anhang Price, R., Elliott, M.N., Zaslavsky, A.M., Hays, R.D., Lehrman, W.G., Rybowski, L., Edgman-Levitan, S. & Cleary, P.D. (2014). Examining the role of patient experience surveys in measuring health care quality. Medical Care Research and Review, 71(5), 522–554.

Crofton, C., Lubalin, J.S., & Darby, C. (1999). Consumer Assessment of Health Plans Study (CAHPS). Foreword [Review]. Medical Care, 37(3 Suppl.), MS1–MS9.

Darby, C., Hays, R.D., & Kletke, P. (2005). Development and evaluation of the CAHPS hospital survey. Health Services Research, 40(6 Pt 2), 1973–1976.

Hays, R.D., Martino, S., Brown, J.A., Cui, M., Cleary, P., Gaillot, S., & Elliott, M. (2014). Evaluation of a care coordination measure for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Medicare survey. Medical Care Research and Review, 71, 192–202.

Holt, J.M. (2019). Patient experience in primary care: A systematic review of CG–CAHPS surveys. Journal of Patient Experience, 6(2), 93–102.

Martino, S.C., Elliott, M.N., Cleary, P.D., Kanouse, D.E., Brown, J.A., Spritzer, K.L., Hays, R.D. (2009). Psychometric properties of an instrument to assess Medicare beneficiaries' prescription drug plan experiences. Health Care Financing Review, 30(3), 41–53.

plans with narrow networks or closed panels or providers who are not accepting new patients have less positive experiences or receive lower quality care in the responses to existing questions on the survey. If care is worse in some MA contracts because of these aspects of how care is provided, the survey functions as intended by identifying and reporting these differences to beneficiaries, contracts, and CMS.

The statistical reliability of the CAHPS measures is high, so that higher star categories correspond to meaningfully better performance. Generally, reliabilities of 0.7 or more are considered high for a quality measure (Price, Elliott, Zaslavsky, et al., 2014). The reliability of Medicare CAHPS measures ranges from 0.76 to 0.92. Contracts may further increase the reliability of their own scores by requesting sample sizes greater than the required minimum.

While the star category bands may appear to be narrow, the reliability of CAHPS measures meet or exceed standards for quality measurement (Adams 2009 [26]), so that higher star categories correspond to meaningfully better performance. While the CAHPS scoring using linear means may make between-plan differences appear to be compressed, the high contract-level reliability establishes excellent ability to differentiate plan performance. Based on the peer-reviewed measurement and quality-measurement literature, experts in measurement generally agree that reliability greater than 0.70 indicates acceptable reliability; reliabilities of 0.80 or greater are preferable for higher-stakes applications (Adams et al. 2010, Elliott et al. 2010; Nunnally & Bernstein, 1994; Roland et al. 2009; Safran et al., 2006).[27]

The differences between CMS's Medicare CAHPS implementation and others largely reflect CMS's use of additional survey items, case-mix adjustment, and reliability and statistical significance criteria to improve the validity, reliability, and accuracy of Medicare CAHPS scores and stars (*https://www.ma-pdpcahps.org/globalassets/ma-pdp/scoring-and-star-ratings/2019-analysis-of-reported-measures.pdf*); several of these beneficial features are not included in other CAHPS implementations. For example, the CMS Medicare CAHPS Getting Appointments and Care Quickly composite includes a highly-reliable item that is not present in alternate versions. The use of percentile cutoffs, combined with reliability and statistical significance testing, reduces the effects of chance and results in reliable, valid star assignment for CAHPS measures. This methodology, combined with highly-reliable underlying scores, ensures that changes in cut points reflect changes in contract performance rather than chance. These changes in cut points ensure that CAHPS Star Ratings continue to accurately differentiate contract performance.

Patient experience is an inherently important dimension of healthcare quality. It is also the case that the preponderance of evidence shows that better patient experience is associated with better patient adherence to recommended treatment, better clinical processes, better hospital patient safety culture, better clinical outcomes, reduced unnecessary healthcare use, and fewer inpatient complications (Anhang Price et al., 2014; Anhang Price et al., 2015).

Medicare CAHPS case-mix adjustment, which is informed by 20 years of research, accounts for factors such as age, health status, and dual eligibility and ensures that contract scores are not influenced by patient-level factors beyond their control. This adjustment ensures that contract-level scores fairly represent all contracts. Analyses of nonresponse in CAHPS data (Elliott et al. 2005; Elliott et al. 2009) have shown little or no evidence of nonresponse bias in the presence of CAHPS case-mix adjustment.

Medicare CAHPS survey vendors have access to beneficiary-level data and are permitted to conduct analyses with these data that do not risk disclosing the identity of respondents to plan sponsors, including restrictions on reporting cell sizes smaller than 11. These restrictions are necessary to ensure the confidentiality and validity of beneficiary responses to the Medicare CAHPS survey.

The collection and processing of CAHPS data undergo a rigorous quality assurance process that includes dual program coding, use of test data sets, team review of products, investigation of outliers, and comparisons to historic results. This quality assurance process is as rigorous as that followed for the production of other quality measures.

Comment: A couple of commenters suggested different updates to the content of the CAHPS survey. A commenter recommended that the Agency for Healthcare Research and Quality (AHRQ) and CMS consider expanding the survey to include questions on accuracy of provider directories and ease of accessing the information. Another commenter noted that questions on the CAHPS survey are not consistent across different lines of business.

Response: The Medicare CAHPS Survey was updated in 2016 to incorporate AHRQ's 5.0 updates to the CAHPS Health Plan Survey. CMS uses the most current version of the CAHPS Health Plan Survey as it is the national standard for measuring and reporting on the experiences of consumers with their health plan, and the only assessment of patient experiences with health plans endorsed by the National Quality Forum. In May 2019, AHRQ published a request for information inviting public comment to inform potential revisions to the Health Plan Survey (84 FR 21340). CMS will give careful consideration to any updates to the CAHPS Health Plan Survey that AHRQ may provide in the future. Additional testing and development to refine CAHPS items in areas such as care coordination is ongoing. With regard to adding questions around provider directories and ease of accessing plan information, specific measures of information seeking, such as experience with written health plan materials, have been explored in the context of CAHPS but have not resulted in reliable measures due to too few plan members reporting experience in the survey samples. CMS is exploring alternate ways of improving the accuracy of plan directories. Differences in CAHPS composite items across lines of business, such as in the Getting Appointments and Care Quickly composite, in some cases reflect additional items that Medicare CAHPS includes to maximize the reliability and validity of the CAHPS measures.

Comment: A commenter supported the increase in the weight for administrative access measures but

[26] *https://www.rand.org/pubs/technical_reports/TR653.html.*

[27] Adams, J.L., Mehrotra, A., Thomas, J.W., & McGlynn, E.A. (2010). Physician cost profiling—reliability and risk of misclassification. New England Journal of Medicine, 362(11), 1014–1021.

Elliott, M.N., Lehrman, W.G., Goldstein, E., Hambarsoomian, K., Beckett, M.K., & Giordano, L.A. (2010). Do hospitals rank differently on HCAHPS for different patient subgroups? Medical Care Research and Review, 67(1), 56–73.

Nunnally, J.C., & Bernstein, I.H. (1994). Psychometric theory (3rd ed.). New York: McGraw-Hill.

Roland, M., Elliott, M., Lyratzopoulos, G., Barbiere, J., Parker, R.A., Smith, P., . . . & Campbell, J. (2009). Reliability of patient responses in pay for performance schemes: Analysis of national General Practitioner Patient Survey data in England. British Medical Journal, 339, b3851.

Safran, D.G., Karp, M., Coltin, K., Chang, H., Li, A., Ogren, J., et al. (2006). Measuring patients' experiences with individual primary care physicians: Results of a statewide demonstration project. Journal of General Internal Medicine, 21, 13–21.

suggested keeping the CAHPS measures at their current weight because the administrative measures already take into account member experience. Another commenter said they would support an increase in access measures because plans have a direct impact on the outcome of these measures and can analyze, pinpoint root causes, and take action to avoid adverse outcomes.

Response: We appreciate these comments. CMS wants to ensure that the experiences of beneficiaries getting needed care, getting appointments and care quickly, care coordination, and ratings of health care quality, for example, are also emphasized with this weight change. MA plans are responsible for providing all of the Part A and B benefits and providing a managed care alternative to the traditional FFS Medicare program. In some cases, the MA plans provide additional (supplemental) benefits. One of the advantages of MA is the MA plan is responsible for coordinating the care among the enrollee's health care providers. Since the primary purpose of the health plan is to ensure their enrollees get needed health care services, patient experience and access measures that focus on whether the enrollee is getting needed care are critical in evaluating whether a plan is fulfilling its fundamental requirements.

Comment: A couple of commenters opposed the weight increase for access measures but also asked for clarification and requested a methodology change to the Call Center measures. A commenter requested CMS consider publishing Call Center results in HPMS on the same frequency as the Part C and Part D Timeliness Study (quarterly) to allow plan sponsors to better align internal testing/monitoring against CMS third-party testing. A commenter asked for clarification on the definition of the ''Call Center,'' noting it is unclear if this encompasses the Star Ratings measure for prospective members or if this is in reference to the member customer service call center.

Response: While we appreciate feedback on the usefulness of the Accuracy and Accessibility Study results and the request for publication of those results quarterly, we cannot do this because of the timing of the study. The Timeliness Study is conducted quarterly, and CMS publishes the results quarterly; conversely the Accuracy and Accessibility Study is conducted once a year, between February and May, and CMS publishes the results once a year, as soon as they are available in August. For purposes of the Star Ratings measure, the prospective customer service call center results are included in the measure calculation. The measure specification has not changed from prior years.

Comment: A few commenters opposed the current appeals measures and, consequently, did not believe the higher weight was prudent. One noted that these measures are distorted because beneficiaries may be unaware of the extent to which they are or are not receiving the proper benefits. The commenter recommended CMS conduct a survey of providers on how efficiently and accurately MA plans make organizational determinations and appeals. A commenter expressed concern regarding increasing the weight for appeals measures citing what they believe are fundamental flaws in these measures. They stated both the plan and Independent Review Entity (IRE) have difficulty reaching sound decisions in the 72 hour timeframe and argued the IRE demonstrates the same lack of medical expertise or misunderstanding of coverage guidelines as the MA plan; the commenter recommended providing more meaningful measures such as independent audits of the MA plans' initial determinations, the frequency with which physicians appeal MA plans initial determinations, the timeliness of initial determinations (using a much shorter standard than 72 hours), and other measures they say capture the patient and provider experience more accurately. A commenter stated health plans should be held accountable for their administrative responsibilities and insurance functions through compliance standards and plan monitoring, not Star Ratings.

Response: CMS clarifies that both Part C appeals measures assess the timeliness of appeals sent to the IRE and how often the IRE agrees with the plan's decisions. The purpose of these measures is not to directly assess the enrollees' comprehension of all of their plan benefits. CMS acknowledges the comments for new measurement suggestions for the Part C appeals process and is actively evaluating these suggestions for future measure development. However, CMS does not agree that there are fundamental flaws in the current Part C Appeals measures. The purpose of the appeals measures is to ensure appeals that are denied are processed in a timely manner and to assess if the denial by the health plan was consistent with the benefit or coverage requirements. CMS reminds plans that they can access timeliness and compliance data in real time at *www.medicareappeal.com* and bring to the attention of the IRE any data discrepancies. CMS disagrees that both the plan and IRE have difficulty making sound decisions in the 72-hour time frame and both lack the medical expertise or misunderstand the coverage guidelines. CMS notes only expedited reconsiderations must be sent to the IRE within 72 hours for Part C appeals (see § 422.590). In these cases this timeframe is required to avoid endangering the life or health of the enrollee or the enrollee's ability to regain or maintain maximum function; thus, a de novo review of an adverse organization determination must be processed quickly. Examples of cases that should be expedited include pre-service skilled nursing facility cases, pre-service acute inpatient care cases and cases in which a physician indicates that applying the standard timeframe for making a determination could seriously affect the life or health of the enrollee or the enrollee's ability to regain maximum function. Medicare health plans have an obligation to determine if an appeal should be expedited, including responding to an enrollee or provider request for expedited determination. We also remind plans that in expedited and standard service appeals, IRE may extend the decision timeframe by up to 14 calendar days if it is in the enrollee's interest.

Please remember if a plan fails to provide the appellant with a reconsidered determination within the required timeframes, this failure constitutes an affirmation of its adverse organization determination, and the plan must submit the case file to the IRE for review. Plans and sponsors must continue to have procedures in place for requesting and obtaining information necessary for making timely and appropriate decisions. The IRE's decision is based on the information gathered during its review process and the IRE must issue a decision within the same appeals timeframe as the plan. Please refer to 42 CFR 426.600(d). Therefore, the timeframes for the plan and the IRE are aligned.

In response to the recommendation that plans be held accountable for their administrative responsibilities and insurance functions through compliance standards and plan monitoring instead of Star Ratings, we assure commenters that this also happens. The Star Ratings measures only focus on two aspects of the appeals processes. Program audits provide a more comprehensive review of a sponsoring organization's compliance with the terms of its contract with CMS, including access to medical services and other enrollee protections required by Medicare. For more information about the program audit process, please see *https://www.cms.gov/files/document/2020-*

program-audit-process-overview.pdf. The purpose of the Star Ratings system is to measure quality of a health and drug plan and to provide information to help beneficiaries make more informed choices. The appeals measures are such indices of quality.

Comment: A few commenters focused their comments on the Complaints about the Health and Drug Plan measures. A commenter said they support a modest increase in weight for these measures because plans are generally able to analyze the root cause of the complaint and implement strategies to address beneficiary concerns. A few commenters noted that complaints not within the plans' control and complaints resulting from CMS policy decisions should be excluded.

Response: CMS thanks the commenter for their support of a modest increase in the weight of the complaints measure. Although a few commenters noted that complaints not within the plans' control and complaints resulting from CMS policy decisions should be excluded, CMS expects plans to be integral in assisting beneficiaries and ensuring their access to care is not disrupted, regardless if they directly created the issue at question, or not. CMS expects health plans and Part D sponsors will assist their enrollees in situations such as these, and help them understand how to correct issues, even if the underlying cause of complaints is not the sponsors' fault. Sponsors have an important responsibility for providing continued access to services. The fact that CMS received a complaint indicates the sponsor has not helped service their enrollee, as Medicare instructs beneficiaries to seek resolution first through their sponsors. If sponsors take the opportunity to assist their enrollees proactively, they will avoid having complaints recorded in the Complaints Tracking Module (CTM). CMS issued guidance in the HPMS memo dated May 10, 2019, Complaints Tracking Module (CTM) File Layout and Updated Standard Operating Procedures, which describes the Plan Request process for plans to submit requests to change incorrect contract assignments, change issue designation (that is, from Plan Issue level to CMS Issue), and change category/subcategory. The memo states that, for matters that are delegated to CMS for handling and/or final resolution, plans are to submit a CMS Issue Change Request and it lists examples of applicable situations. In the SOP Appendix A, CMS lists the subcategories and notes which subcategories are excluded from plan performance metrics.

Comment: A few commenters focused their comments on the disenrollment measure, Members Choosing to Leave the Plan, stating that the measure is flawed and misrepresents some changes in enrollment as dissatisfaction. They suggest CMS consider excluding members who switch plans but stay with the same parent organization, as it may actually suggest a high level of satisfaction with the parent organization. A commenter stated the measure is extremely volatile and can be impacted by many factors beyond a member's experience with their health plan, including job loss/movement, changes in individual finances, provider changing plans, relocations and changes in member needs.

Response: CMS appreciates these comments, but disagrees that the current specification for this measure is flawed. This measure reflects voluntary movements from one contract to another. For example, if a change in the provider network results in a beneficiary changing contracts, this reflects a decision by the beneficiary that the current contract is no longer providing the care or access to services that they want. Similarly, if the health status of the enrollee changes, and the current plan is not meeting the enrollee's changing health needs, this may result in a voluntary disenrollment and should be reflected in this measure.

This measure is a contract-level measure focused on quality at that level; therefore, disenrollments are considered voluntary even when a member enrolls into a different contract under the same parent organization. The member is changing from one contract to another for a reason and this should be reflected in this measure. If we were to change the measure specification to consider disenrollments as no longer voluntary when a member enrolls into another contract under the same parent organization, this change would be advantageous to larger parent organizations that have multiple contracts.

There are only 4 disenrollment codes used in this measure (11—Voluntary Disenrollment through plan, 13—Disenrollment because of enrollment in another Plan, 14—Retroactive and 99—Other (not supplied by beneficiary)). We agree that there are reasons for disenrollment that should not be counted against the plan. For example, enrollment changes because of a contract service area reduction, a PBP termination, LIS reassignments, passive enrollment of the enrollee into a Demonstration (MMP), and changes in residence out of the service area are not counted in the measure.

Comment: Some commenters supported the weight increase, indicating they appreciate CMS adding further emphasis on the voice of the patient. Some argued that better patient experience has been shown to improve patient compliance with medical advice.

Response: CMS appreciates the commenters' support of our proposal.

Comment: Several commenters expressed concern about implementing a weighting change during the COVID–19 pandemic because of the current uncertainty how the public health emergency will impact care delivery and patient experiences going forward. One noted this weight change would not give health plans adequate time to adjust for the volatility and inconsistency of CAHPS responses and difficulties in measurement during this time. A couple of commenters noted that depending on the state of the pandemic, additional weight afforded to the current patient experience and complaints measures will not accurately capture plan performance during this public health emergency and crisis. Another commenter noted patient experience data during this period may not be particularly accurate or useful as a measure of overall performance of Medicare Advantage or individual plans due to how the pandemic may impact how beneficiaries may respond to these types of surveys.

Response: The changes to the weighting of patient experience/complaints and access measures apply to the 2021 measurement year, not the 2020 measurement year when the pandemic first started. CMS agrees that there is a lot of uncertainty about how COVID–19 will impact the healthcare system and quality measurement and recognizes the challenges placed on the healthcare system and Part C and D plans; however, plans have until the 2021 measurement year to adjust their processes to account for the impact of COVID–19 on Star Ratings measures. One thing that is certain for plans is how much they focus on addressing their members' needs during the time of a pandemic. We believe that given the uncertainty during such times, it is even more important that plans be proactive, anticipate enrollees' needs, and work with them in a customized way to mitigate any challenges that enrollees might face in a pandemic environment. Therefore, it is important to move forward with these Star Ratings changes to further emphasize the importance of patient experience/complaints and access measures at this time. We reiterate that patient experience is an inherently important dimension of

healthcare quality and associated with better health outcomes and improved care delivery. This is critical information to help beneficiaries make more informed choices.

Comment: Some commenters noted that different areas of the country are experiencing different limitations of health care resources related to COVID–19, some of which may require redeployment of resources, so differences in CAHPS and HOS survey scores may be neither meaningful nor appropriate to compare plan performance. They request that CMS re-evaluate these measures after the COVID–19 crisis is resolved. Several commenters noted their concern about the long-term impact of the public health crisis on respondents' physical and mental health, and their perception of the health care system and health plans.

Response: CMS recognizes the challenges that COVID–19 has placed on the healthcare system and quality measurement. We understand the concern that it may impact how beneficiaries respond to CAHPS surveys and, consequently, the CAHPS measure scores. To that end, we believe that this would be a great opportunity for plans to focus even more on supporting their enrollees, being proactive and anticipating enrollees' needs, and working with them in a customized way to mitigate any challenges that enrollees might face in a pandemic environment. We are continuing to monitor whether additional Star Ratings adjustments need to be proposed for future years.

Comment: Several commenters stated the weight increase should not proceed at this time due to widespread restricted access to providers due to concern about capacity and public safety as a result of COVID–19, and the unknown duration of such restrictions. For example, beneficiaries may not be able to assess their experience with in-person encounters, and responses may be biased by exigencies secondary to COVID–19. One notes the proposed CAHPS weight changes for the 2021 measurement period provide little time for health plans to adjust for the volatility and consistency of CAHPS responses and difficulties in measurement.

Response: Again, we believe that this would be the ideal time for plans to take the opportunity to focus even more on supporting their enrollees, being proactive and anticipating enrollees' needs, and working with them in a customized way to mitigate any challenges that enrollees might face in a pandemic environment, particularly challenges in accessing services. As previously stated, these changes are for the 2021 measurement period so plans have time to adjust to the impacts of COVID–19. Even in a pandemic environment, increasing the weight for experience measures will encourage plans to focus on an enrollee's experience with the plan (for example, plan communication, plan innovation, mitigation of access issues). CMS will continue to monitor the impact of the public health emergency on quality measurement. For CAHPS measures, widespread changes in industry performance should be reflected in the cut points.

Summary of Regulatory Changes

After consideration of the comments and for the reasons indicated in the proposed rule and in the responses to comments, we are finalizing the provisions regarding the weight increase for patient experience/complaints and access measures as proposed at §§ 422.166(e)(1)(iii) and (iv) and 423.186(e)(1)(iii) and (iv).

In the proposed rule, we stated that if both Tukey outlier deletion and increasing the weight of patient experience/complaints measures and access measures were adopted the net savings for the Medicare Trust Fund would be $368.1 million for 2024, increasing to $999.4 million for 2030. We are finalizing the use of Tukey outer fence outlier deletion as proposed but to begin one year later, with the 2024 Star Ratings, and are finalizing the proposal to increase the weights of the patient experience and complaints measures and the access measures to 4 for the 2023 Star Ratings. Based on the combination of these final policies, we project the net cost to the Medicare Trust Fund would be $345.1 million for 2024, increasing to a net savings of $999.4 million for 2030. There is a net cost for 2024 since the increase in weight for patient experience/complaints measures and access measures results in an overall increase in the highest ratings for MA contracts, while in future years with the addition of the Tukey outlier deletion there is an overall decrease in the highest ratings for MA contracts.

5. Reclassification of the Statin Use in Patients With Diabetes (SUPD) Measure (§§ 422.164(d)(2), 423.184(d)(2)

Currently, the SUPD measure specifications require two diabetes medication fills to meet the denominator while only a single fill of a statin therapy is required to meet the numerator criteria. Recently, the Pharmacy Quality Alliance (PQA), the measure steward, has clarified SUPD as a process measure in a Frequently Asked Question (FAQ) (the FAQ can be found at *https://www.pqaalliance.org/measures-overview#supd*), therefore CMS no longer believes that the intermediate outcome measure classification for the SUPD measure is appropriate. We proposed to modify the classification of the SUPD measure from an intermediate outcome measure to a process measure, starting with the 2023 Star Ratings, based on data from the 2021 measurement period.

We received the following comments related to our proposal, and our responses follow:

Comment: The majority of commenters supported modifying the SUPD measure classification from an intermediate outcome to a process measure, changing the weight from 3 to 1. Commenters noted that outcomes are not measured in SUPD since it only requires a single fill of a statin medication. They agreed that SUPD is a process measure that is based on an important procedural intervention but does not capture a therapeutic outcome since SUPD does not monitor the medication adherence of a statin over a course of treatment. In addition, commenters noted that classifying SUPD as a process measure is consistent and aligns with the Part C Statin Therapy for Patients with Cardiovascular Disease measure.

Response: CMS appreciates the commenters' support of this proposal. It is consistent with the clarification from the measure steward, the Pharmacy Quality Alliance (PQA), in 2019 that SUPD is a process measure based on the National Quality Forum's (NQF) criteria.

Comment: A few commenters that support CMS's proposal to modify the SUPD measure category to a process measure also noted that CMS should exercise caution when creating additional measures in the Star Ratings program or changing measure categorizations. Commenters were concerned that measure weights are being changed too rapidly. One commenter also expressed concerns with selecting the SUPD measure and recommends that CMS consider replacing SUPD with the Healthcare Effectiveness Data and Information Set (HEDIS) measure Statin Therapy for Patients with Diabetes (SPD).

Response: CMS thanks the commenters for this feedback. CMS carefully evaluates all of the measures incorporated in the Star Ratings. CMS will continue to monitor each of the measures included in the Star Ratings as well as future measures incorporated into the Star Ratings. CMS also carefully evaluates the weights of each measure.

The weights are based on measure type. Typically, CMS aligns the measure specifications with the measure steward. The Statin Therapy for Patients with Cardiovascular Disease (SPC) is already included in the Part C Star Ratings while the SUPD measure is included for Part D. CMS first discussed the HEDIS SPD and SPC measures, and the PQA SUPD measure in the 2016 Call Letter. As stated in the 2017 Call Letter, the SPD measure overlapped with the SUPD measure. Therefore, CMS added only one of the HEDIS measures (the Part C SPC measure) to the 2017 display page as well as the Part D SUPD measure after consideration of stakeholder feedback through the Call Letter process. CMS gained experience with calculating and reporting the measures and added SPC and SUPD to the Star Ratings as announced in the 2019 Call Letter.

Comment: Commenters provided feedback on the timeline proposed for reclassifying SUPD starting with the 2023 Star Ratings (using 2021 data). Some noted that SUPD is a process measure that has not changed in terms of specifications to warrant retaining SUPD as an intermediate outcome measure for the 2021 and 2022 Star Ratings. Additionally, commenters were concerned that retaining the classification as an intermediate outcome with a weight of 3, rather than immediately reclassifying SUPD as a process measure with a weight of 1, could lead to confusion, and is inconsistent with the guidance of expert measure developers, which could lead to instability for the Star Ratings. However, there were a few commenters who supported CMS's proposed timeline as it would take into consideration plan efforts and coordination needed to account for the SUPD measure reclassification.

Response: Reclassifying SUPD as a process measure (including its weight), is a substantive change that must be proposed and finalized through rulemaking as required by § 423.184(d)(2). In the April 2018 final rule, CMS finalized the weight of 3 for SUPD for the 2021 and 2022 Star Ratings. In the February 2020 proposed rule, CMS proposed to reclassify SUPD as a process measure with a weight of 1 for future years, starting with the 2023 Star Ratings. This timeline and approach is consistent with the April 2018 final rule which outlined that a key tenet of the Star Ratings program is to make changes prior to the measurement year and to give sponsors enough lead time, in order to ensure greater transparency and stability for the Star Ratings program for plan sponsors.

Comment: A few commenters opposed reclassifying SUPD to a process measure or changing the weight of 3 to 1. Commenters noted that statin use for diabetic patients is an important and valuable intervention; thus, SUPD should remain classified as an intermediate outcome measure. Additionally, commenters were concerned with reclassifying SUPD and lowering the weight in the absence of outcomes-focused measures within the Star Ratings that address appropriate care for diabetes and cardiovascular care, given the strong correlation between the two conditions.

Response: CMS agrees that SUPD is an important measure that is included in the Star Ratings. Per NQF's definition of process measures, CMS agrees that prescribing a statin is a step in providing good care, rather than an outcome of such care. Furthermore, the measure steward, PQA, has classified SUPD as a process measure based on NQF's definition. As such, CMS proposed to reclassify SUPD as a process measure with a weight of 1 to align with the industry definitions.

Comment: Several commenters gave specific feedback regarding exclusion criteria related to SUPD, such as beneficiaries predisposed to statin intolerance or history of rhabdomyolysis. Commenters were concerned that only using prescription claims limited the types of exclusions included in SUPD. In addition, a few commenters noted this quality measure does not reflect or capture achievable outcomes related to reversing chronic disease or decreasing cardiovascular morbidity and mortality.

Response: We thank the commenters for the feedback, but these comments are out of scope for this rule since the comments do not reference the reclassification of the SUPD measure and the subsequent change to the measure weight. CMS will share the measure specification comments with the measure steward, PQA, about the additional populations that were recommended for exclusion, the concerns with using prescription claims and exclusions, and to consider future measures on outcomes related to reversing chronic disease.

Comment: A commenter was concerned with the current COVID–19 public health emergency and how it could impact the accuracy of the measure.

Response: Thank you for this feedback. CMS will continue to monitor the impact of the public health emergency on the SUPD measure.

After considering the comments we received and for the reasons outlined in the proposed rule and our responses to the comments, we are finalizing the proposal without modification. Starting with the 2023 Stars Rating, the SUPD measure will be reclassified as a process measure with a weight of 1. This change will be reflected in the Medicare Part C & D Star Ratings Technical Notes for the 2023 Star Ratings, which are based on the 2021 measurement period.

C. Medical Loss Ratio (MLR) (§§ 422.2420, 422.2440, and 423.2440)

In the February 18, 2020 proposed rule (85 FR 9008), we proposed certain modifications to the medical loss ratio (MLR) regulations for the Medicare Part C and Part D programs. Briefly, we proposed to amend § 422.2420(b)(2)(i) to allow MA organizations to include in the MLR numerator as ''incurred claims'' all amounts paid for covered services, including amounts paid to individuals or entities that do not meet the definition of ''provider'' as defined at § 422.2. We also proposed to codify the definitions of partial, full, and non-credibility and credibility factors that we published in the May 2013 Medicare MLR final rule (78 FR 31295 through 31296). Finally, for MA medical savings account (MSA) contracts receiving a credibility adjustment, we proposed to apply a deductible-based adjustment to the MLR calculation in order to recognize that the variability of claims experience is greater under health insurance policies with higher deductibles than under policies with lower deductibles.

1. Background

An MLR is expressed as a percentage, generally representing the percentage of revenue used for patient care rather than for such other items as administrative expenses or profit. The proposed rule provided background on the Part C and Part D medical loss ratio (MLR) requirements, including the statutory and regulatory authority. The Part C statute, at section 1857(e)(4) of the Act, expressly imposes a minimum medical loss ratio requirement for MA plans. Because section 1860D–12(b)(3)(D) of the Act incorporates by reference the requirements of section 1857(e) of the Act, these MLR requirements also apply to the Medicare Part D program. In the May 2013 Medicare MLR final rule, which codified the MLR requirements for Part C MA organizations and Part D sponsors (including organizations offering cost plans that offer the Part D benefit) in the regulations at 42 CFR part 422, subpart X, and part 423, subpart X. In the April 2018 final rule (83 FR 16440), we changed certain aspects of

the MLR calculation and revised the reporting requirements.

For contracts for 2014 and later, MA organizations and Part D sponsors are required to report their MLRs and are subject to financial and other sanctions for a failure to meet the statutory requirement that they have an MLR of at least 85 percent (see §§ 422.2410 and 423.2410). The statute imposes several levels of sanctions for failure to meet the 85 percent minimum MLR requirement, including remittance of funds to CMS, a prohibition on enrolling new members, and ultimately contract termination. The minimum MLR requirement creates incentives for MA organizations and Part D sponsors to reduce administrative costs, such as marketing costs, profits, and other uses of the funds earned by plan sponsors, and helps to ensure that taxpayers and enrolled beneficiaries receive value from Medicare health and drug plans.

2. Regulatory Changes to Incurred Claims (§ 422.2420)

Section 422.2420(a) of the regulations sets forth a high-level definition of the MLR as the ratio of the numerator, defined in paragraph (b), to the denominator, defined in paragraph (c). In general, MA costs are in the numerator and revenues are in the denominator. Section 422.2420(b)(1) identifies the three components of the MLR numerator for MA contracts that are not MSA contracts: (1) Incurred claims (as defined in paragraphs (b)(2) through (4)); (2) the amount of the reduction, if any, in the Part B premium for all MA plan enrollees under the contract for the contract year; and (3) expenditures under the contract for activities that improve health care quality, which are described in detail at § 422.2430. For MA MSA contracts, the three components of the MLR numerator are (1) incurred claims (as defined in paragraphs (b)(2) through (4)); (2) expenditures under the contract for activities that improve health care quality; and (3) the amount of the deposit into the Medicare savings account for MSA enrollees. We proposed to revise the regulation text regarding the incurred claims portion of the numerator.

Under current § 422.2420(b)(2)(i), incurred claims include direct claims that the MA organization pays to providers (including under capitation contracts) for covered services (described at paragraph (a)(2) of that section) that are provided to all enrollees under the contract. Section 422.2 defines a ''provider'' for purposes of the MA regulations as any individual or entity that is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the state, or to deliver those services if such licensing or certification is required by State law and regulation. Per § 422.2420(a)(2), ''covered services'' are the benefits defined at § 422.100(c): basic benefits, mandatory supplemental benefits, and optional supplemental benefits.

As explained in greater detail in section II.A. of this final rule and sections II.A. and VI.F. of the proposed rule, we proposed revisions to the regulations at § 422.100 in order to codify subregulatory guidance and statutory changes that have expanded the types of supplemental benefits that MA plans may include in their plan benefit packages (PBPs). The proposed amendment to § 422.100(c)(2) would codify our longstanding interpretation of the statute to require a supplemental benefit to be an item or service (1) that is primarily health related; (2) for which the MA organization incurs a non-zero direct medical cost; and (3) that is not covered by Medicare Parts A, B, or D. In the 2019 Call Letter, issued on April 2, 2018, we announced that we had reinterpreted the scope of what would be ''primarily health related'' in order to meet this criterion to be a supplemental benefit. Under this reinterpretation, to be considered ''primarily health related,'' a supplemental benefit must diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional or psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization; we explained in the contract year 2019 Call Letter how this means the benefit must focus directly on an enrollee's health care needs and must be medically appropriate and recommended by a licensed medical professional as part of a health care plan, but it need not be directly provided by one. As part of proposed § 422.100(c)(2), to account for the types of supplemental benefits that may be offered under the policy changes addressed in section II.A. of this final rule and sections II.A. and VI.F. of the proposed rule, we also proposed specific provisions to address permissible supplemental benefits that are not primarily health related and for which the non-zero direct cost incurred must be a non-administrative direct cost (if it is not a medical cost).

In § 422.102(f), as finalized in section II.A. of this final rule, we are codifying regulation text implementing amendments made by the BBA of 2018 to section 1852(a)(3) of the Act to expand the types of supplemental benefits that may be offered to chronically ill enrollees, starting in contract year 2020. Under paragraph (D) of section 1852(a)(3) of the Act, as added by the BBA of 2018, MA organizations may provide special supplemental benefits for the chronically ill (SSBCI) that are not primarily health related to chronically ill enrollees, as long as the item or service has the reasonable expectation to improve or maintain the chronically ill enrollee's health or overall function.

As explained in the proposed rule, under current § 422.2420(b)(2)(i) of the MA MLR regulations, incurred claims in the MLR numerator include direct claims paid *to providers* for covered services furnished to all enrollees under an MA contract. The amendment to section 1852(a)(3)(D) of the Act has expanded the types of supplemental benefits that can be ''covered services'' under an MA plan. The amendments to implement that change at § 422.102(f) and the continuation of our policy for establishing what it means for a benefit to be primarily health related, both, mean that permissible supplemental benefits might include items and services that would not typically be furnished by an individual or entity that is a ''provider'' as defined at § 422.2. A provider, as defined in § 422.2, is an individual or entity engaged in the delivery of health care services and who is licensed or certified by the State to engage in that activity in the State. To ensure that amounts that an MA organization pays for covered services to individuals or entities that are not health care providers are included in incurred claims under current § 422.2420(b)(2)(i), we proposed to amend the regulation to remove the specification that incurred claims are payments to providers for covered services.

The proposed rule explained that, if incurred claims do not include amounts an MA organization pays to individuals or entities that are not providers for supplemental benefits, including SSBCI, these expenditures could still potentially be included in the MLR numerator as expenditures related to quality improvement activities (QIAs). To be considered a QIA under § 422.2430, a benefit must be an activity that falls into one or more of the categories listed in paragraph (a)(2) of that section, and it must be designed for the purposes listed in paragraph (a)(3): (1) To improve health quality; (2) to increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results; (3) to be directed toward individual enrollees,

specific groups of enrollees, or other populations as long as enrollees do not incur additional costs for population-based activities; and (4) to be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations. As explained in the proposed rule, although we believe that supplemental benefits that meet the expanded ''primarily health related'' standard at proposed § 422.100(c)(2)(ii)(A) and non-primarily health related SSBCI described at § 422.102(f) could potentially qualify as QIAs under § 422.2430, whether a particular benefit met all of the requirements of that regulation would need to be determined on a case-by-case basis. With our proposed amendments to § 422.2420(b)(2)(i), this case-by-case determination would no longer be necessary for services that are covered under the plan benefit package offered by an MA plan pursuant to the statute and regulations governing the MA program; all amounts paid for covered services would be included in the incurred claims portion of the MLR numerator.

As explained in the proposed rule, we believe that including in the MLR numerator amounts MA organizations spend on supplemental benefits that meet the ''primarily health related standard'' at proposed § 422.100(c)(2)(ii)(A) and on non-primarily health related SSBCI under § 422.102(f), as amended in this final rule, is consistent with the purpose of the MA MLR requirement. As explained in the May 2013 Medicare MLR final rule adopting the MLR regulations (78 FR 31284), the MLR requirement creates an incentive for MA organizations to reduce administrative costs such as marketing costs, profits, and other uses of plan revenues, and to help ensure that taxpayers and enrolled beneficiaries receive value from Medicare health plans.

In order to ensure that the MLR numerator includes amounts MA organizations spend on supplemental benefits that are ''primarily health related'' under our current guidance and on non-primarily health related SSBCI under § 422.102(f), as adopted in this final rule, we proposed the following modifications to the regulation at § 422.2420(b)(2)(i):

- Remove the specification that incurred claims are direct claims that an MA organization pays *to providers* for covered services provided to all enrollees under the contract.
- Remove the specification that incurred claims include payments under capitation contracts *with physicians*.
- Replace the phrase ''direct claims,'' which customarily refers to billing invoices providers submit to payers for reimbursement, with the general term ''amounts.''

As amended under our proposal, § 422.2420(b)(2)(i) would include in incurred claims all amounts that an MA organization pays (including under capitation contracts) for covered services, regardless of whether the recipient of the payment is a provider as defined in § 422.2. Including in incurred claims amounts spent on these expanded supplemental benefits, as proposed, avoids creating uncertainty over whether payments for such covered services could otherwise be included in the MLR numerator (for example, as QIA-related expenditures), and it is consistent with our determination in the May 2013 Medicare MLR final rule (78 FR 31289) that incurred claims should reflect the benefit design under the contract.

We received 27 comments on the proposed amendments to § 422.2420(b)(2)(i). The following is a summary of the comments we received on the proposal and our responses:

Comment: The majority of commenters supported the proposal. Many commenters believed that including in the MLR numerator as incurred claims all payments for covered services would provide greater certainty and reduce plan burden by eliminating the need to assess whether individual benefits meet the criteria to qualify as QIAs under § 422.2430. A number of commenters believed that the proposed change would encourage the expansion of supplemental benefits to address social barriers to care and MA enrollees' other health needs. A few commenters commended us for recognizing the role played by individuals and entities that are not providers in implementing the expanded supplemental benefit flexibility. A couple of commenters noted that they agreed with our view that including in incurred claims amounts spent on these expanded supplemental benefits is consistent with our prior determination that incurred claims should reflect the benefit design under the contract.

Response: We thank the commenters for their support. We reiterate that under our proposal and this final rule, only amounts expended by the MA organization for covered services, which must meet the standards of the MA program for coverage, can be included in the MLR numerator as incurred claims.

Comment: A commenter supported the proposal but requested that we clarify that the incurred claims portion of the MLR numerator will include capitated payments by MA organizations to clinical risk-bearing entities (for example, Independent Practice Associations (IPAs), Physician Hospital Organizations (PHOs), and Accountable Care Organizations (ACOs)) that include amounts for both medical and administrative services, provided the arrangement satisfies a four-factor test that was originally set forth in a guidance document [28] related to the MLR rules that apply to issuers of employer group and individual market private insurance (hereinafter referred to as the ''commercial MLR rules''), and later incorporated into our annual MLR Data Form Filing Instructions for MA organizations and Part D sponsors. The commenter expressed concern that, if the four-factor test does not remain in place, all capitated payments to providers would need to be divided between medical services and delegated administrative services, and then aggregated up to the plan level to determine the amount to be excluded from the MLR as administrative costs.

Response: The amendment to § 422.2420(b)(2)(i), as proposed and finalized, includes in incurred claims all amounts that an MA organization pays (including under capitation contracts) for covered services, regardless of whether the recipient of the payment is a provider as defined in § 422.2. This revision removes the specification that the recipient of a payment for a covered service must be a provider (or a physician, in the case of capitated payments) to be included in incurred claims. The proposed change would not, if finalized, exclude from the incurred claims portion of the MLR numerator any payments that could be included in the numerator as incurred claims under the current MLR rules. However, this amendment also does not authorize inclusion in the numerator of costs that are excluded from incurred claims, such as administrative expenses addressed in § 422.2420(b)(4).

The four-factor test referenced by the commenter has been incorporated into our annual MLR Data Form Filing Instructions (formerly the MLR Report Filing Instructions) (OMB control no.

[28] CCIIO Technical Guidance (CCIIO 2012—001): Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule. February 12, 2012.

0938–1232) (CMS–10476) for each contract year since contract year 2014. The instructions specify that amounts paid by an MA organization or Part D sponsor to clinical risk-bearing entities can be included in the MLR numerator as incurred claims if the following criteria are met:

(1) The entity contracts with an issuer to deliver, provide, or arrange for the delivery and provision of clinical services to the issuer's enrollees but the entity is not the issuer with respect to those services;

(2) The entity contractually bears financial and utilization risk for the delivery, provision, or arrangement of specific clinical services to enrollees;

(3) The entity delivers, provides, or arranges for the delivery and provision of clinical services through a system of integrated care delivery that, as appropriate, provides for the coordination of care and sharing of clinical information, and which includes programs such as provider performance reviews, tracking clinical outcomes, communicating evidence-based guidelines to the entity's clinical providers, and other, similar care delivery efforts; and

(4) Functions other than clinical services that are included in the payment (capitated or fee-for-service) must be reasonably related or incident to the clinical services, and must be performed on behalf of the entity or the entity's providers.

Payments to risk-bearing entities that include payments for administrative functions performed on behalf of the entity's member providers are incurred claims for purposes of § 422.2420 if all four factors outlined above are met.[29] However, to the extent that administrative functions are performed on behalf of the MA organization or Part D sponsor, that portion of the organization's or sponsor's payment that is attributable to administrative functions may not be included in incurred claims. This is the case regardless of whether payment is made according to a separate, fee-for-service payment schedule or as part of a global, capitated fee payment for all services provided.[30] We will continue to use this four-factor test to determine whether an MA organization can include payments to clinical risk-bearing entities.

Comment: A commenter expressed concern that the proposed changes to the definition of ''incurred claims'' could be interpreted as sufficiently broad to permit MA plans and PDPs to include in the MLR numerator costs associated with pharmacy benefit manager (PBM) services due to the nexus between those services and beneficiary access to covered drugs. The commenter was concerned in particular that the proposed change would allow MA organizations and Part D sponsors to include costs for implementing utilization management tools and strategies in the MLR numerator as incurred claims.

Response: We appreciate the commenter's concerns. Amending § 422.2420(b)(2)(i) as proposed to include in incurred claims amounts paid for covered services, regardless of whether the payment is made to a provider, does not allow MA organizations or Part D sponsors to include in the MLR numerator amounts that are identified as non-claims costs and excluded from incurred claims under our current rules. These non-claims costs that continue to be excluded from the MLR numerator include amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management (§ 422.2420(b)(4)). We note, however, that our current rules permit a clinical-risk bearing entity's costs related to utilization management and other administrative services to be included in incurred claims if all four factors outlined in the previous response are met. In addition, consistent with CCIIO's Technical Guidance,[31] our MLR Data Form Filing Instructions specify that when a third party vendor, through its own employees,[32] provides clinical services directly to enrollees, the entire portion of the amount the issuer pays to the third party vendor that is attributable to the third party vendor's direct provision of clinical services should be considered incurred claims, even if such amount includes reimbursement for administrative costs directly related to the vendor's direct provision of clinical services.[33]

Comment: A commenter opposed the proposal because they believed that including all payments for covered services in the incurred claims portion of the MLR numerator would be an unnecessary and inappropriate deviation from the commercial MLR rules, which only include payments to non-providers in the MLR numerator if they meet the requirements for QIA-related expenditures. The commenter expressed approval for the approach we took in the May 2013 Medicare MLR final rule, which was to use the commercial MLR rules as a reference point for developing the MLR rules for Medicare Advantage and Part D (hereinafter referred to as the ''Medicare MLR rules'') and to only depart from the commercial rules to extent necessary and appropriate given the Medicare context (78 FR 31285, 31290). The commenter stated the proposed rule did not identify any reason that the Medicare context makes it necessary and appropriate to depart from the requirement in the commercial MLR rules that incurred claims be paid to providers for covered services. The commenter asserted that the Medicare context does not meaningfully differ from the commercial context with respect to the benefits at issue.

Response: We respectfully disagree with the commenter. We continue to believe that it is important that we align the Medicare MLR rules with the commercial MLR rules in order to limit the burden on organizations that participate in both markets, and to make commercial and Medicare MLRs as comparable as possible for comparison and evaluation purposes. However, as stated in the February 2013 Medicare Program; Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs Proposed Rule (78 FR 12428 through 12429) (hereinafter referred to as the ''February 2013 Medicare MLR proposed rule''), we also recognize that the commercial MLR rules may need to be revised in order to fit unique

[29] For example, a bundled payment to an Independent Practice Association (IPA) or similar entity for providing clinical services to enrollees which includes: The IPA processing claims payments to its member providers and submitting claims reports to issuers on behalf of its providers; performing provider credentialing to determine a provider's acceptability into the IPA network; and developing a network for its providers' benefit, can be included in incurred claims.

[30] For example, payment for processing claims in order to issue explanations of benefits (EOBs) to enrollees and handling any stage of enrollee appeals cannot be included in incurred claims. Payments for non-clinical services for which the contract between the clinical risk-bearing entity, such as an IPA, and the MA organization or Part D sponsor contains a ''clawback'' provision are not considered incurred claims for MLR reporting purposes.

[31] *See, for example,* the May 13, 2011 CCIIO Technical Guidance (CCIIO 2011–002), Q&A #12, available at: *https://www.cms.gov/CCIIO/Resources/Files/Downloads/mlr-guidance-20110513.pdf.*

[32] The term ''through its own employees'' does not include a third party vendor's contracted network of providers because such network providers are not considered employees of the third party vendor.

[33] The MLR Data Form Filing Instructions include the example of a Part D sponsor that contracts with a pharmacy benefit manager (PBM) to provide clinical services directly to enrollees through a mail order pharmacy. The instructions explain that the sponsor's payments to the PBM for mail order pharmacy services provided directly by the PBM's employees, including administrative costs related to the PBM's direct provision of such mail order pharmacy services, would be included in the sponsor's incurred claims.

characteristics of the MA and Part D programs. We believe that it is appropriate that we depart from the commercial MLR rules and expand the meaning of ''incurred claims'' to include covered services furnished by individuals and entities that are not providers, as proposed. The amendment to section 1852(a)(3)(D) of the Act by the BBA of 2018 to expand the types of supplemental benefits that can be ''covered services'' under an MA plan and the implementation of that change at § 422.102(f), as well as CMS' reinterpretation of what it means for a supplemental benefit offered by an MA plan to be primarily health related, mean that permissible supplemental benefits might include items and services that would not be furnished by a ''provider'' as defined at § 422.2. As we explained in the contract year 2019 Call Letter, a benefit is primarily health related if it diagnoses, prevents, or treats an illness or injury, compensates for physical impairments, acts to ameliorate the functional or psychological impact of injuries or health conditions, or reduces avoidable emergency and healthcare utilization; and while we indicated that supplemental benefits must be medically appropriate and recommended by a licensed provider, we acknowledged that they might not be directly provided by a health care professional. Because SSBCI are only required to have a reasonable expectation of maintaining or improving the health or overall function of the chronically ill enrollee and are not required to be primarily health related, we believe those benefits can be provided by someone who is not a health care professional. We are concerned that uncertainty about whether payments for these benefits can be included in the MLR numerator may make MA organizations less inclined to include them in their plan offerings. We believe that it is contrary to Congress' intent in amending section 1852(a)(2)(D) of the Act, and that it undermines CMS' efforts to provide MA organizations with additional flexibility to meet beneficiaries' health needs through supplemental benefits, if the MLR fails to adapt to changes in the permissible benefit design and ultimately deters MA organizations from offering those benefits. In addition, we note that section 2718 of the Public Health Service Act specifies that commercial MLRs shall reflect the percentage of total premium revenue spent ''on reimbursement for clinical services provided to enrollees,'' QIAs, and non-claims costs (which are excluded from the MLR numerator). By contrast, section 1857(e)(4) of the Act, which sets forth the minimum MLR requirement for the MA program, does not require that the portion of the MLR numerator consisting of non-QIA expenditures should be for ''clinical services'' or otherwise specify how the Secretary should calculate Medicare MLRs. Although the commercial and Medicare MLR requirements were both created by the Affordable Care Act of 2010, the statute gives the Secretary greater flexibility in determining how to integrate an MLR requirement into the Medicare program. We continue to use this flexibility to revise the calculation of the Medicare MLR as appropriate based on the unique characteristic of the MA and Part D programs, and we believe that amendment here is such an appropriate change.

Comment: A commenter believed that the proposed change was both unnecessary and unlikely to be effective as a means of encouraging MA organizations to expand their supplemental benefit offerings. The commenter cited data showing that MA organizations had been increasing their supplemental benefit offerings in recent years, which the commenter attributed to previous rule changes. The commenter recommended that instead of adjusting the MLR calculation to encourage the expansion of coverage of supplemental benefits, we should address the barriers to providing supplemental benefits that have been identified by MA organizations—specifically, upfront costs, trade-offs among benefits, return on investment, and provider availability. The commenter cautioned that the proposal may have unintended, negative impacts on non-supplemental benefit coverage, but the commenter did not specify what it meant by non-supplemental benefit coverage or what those negative impacts might be.

Response: We thank the commenter for their feedback and recommendations. As indicated in our response to other comments, we proposed to revise the meaning of ''incurred claims'' to include payments for covered services furnished by individuals or entities that are not providers as defined at § 422.2 in order to avoid creating uncertainty about whether expenditures for supplemental benefits can be included in the MLR numerator, which might deter MA organizations from offering those benefits. Although the purpose of our proposal was not to give MA organizations an incentive to offer expanded supplemental benefits, as noted above, we did receive numerous comments, some of which were submitted by MA organizations, which expressed support for the proposed change because the commenters believed it would encourage plans to offer expanded supplemental benefits. Our efforts to change how supplemental benefits are accounted for in the MLR numerator do not preclude us from pursuing other opportunities that are appropriate for CMS to take to promote the expansion of supplemental benefits.

Comment: A commenter requested that we clarify in final rulemaking the review and enforcement actions we undertake to ensure that QIA is not abused at the expense of MA enrollees. Another commenter requested that we closely examine all MA activities that are currently categorized as QIA to ensure that their utilization improves quality.

Response: At present, we do not actively collect information on MA organizations' QIA expenditures. As a result of change to the MLR reporting requirements finalized in the April 2018 final rule (83 FR 16674), MA organizations are not required to include in their annual MLR submissions information on their QIA expenditures. We have the authority under § 422.2480 to conduct selected audit reviews of the data reported under § 422.2460, which includes the capability to request detailed data regarding the QIA expenditures included in the Medicare MLR, in order to determine that the MLR and remittance amounts were calculated and reported accurately, and that sanctions were appropriately applied. MA organizations are required to attest to the accuracy of the MLR data submitted. In addition, we note that MA organizations and Part D sponsors are required to submit and attest to the data that details their spending on enrollee health care services as part of their annual bids.

Comment: Several commenters requested that we expand our proposal to include in incurred claims all expenditures related to combating COVID–19.

Response: The commenters did not provide specific information on the types of expenditures they wish to make that they believe would not already be included in the MLR numerator as incurred claims under our proposal. Without more detailed information, we are unable to determine whether including the expenditures that the commenters are contemplating in incurred claims would in fact necessitate a modification to our proposal, or whether there is logical outgrowth to make such a modification

or whether it is consistent with our overall policies on the Medicare MLR.

Comment: We received several recommendations for additional changes to the MLR requirements that are outside the scope of this final rule. A commenter recommended that we delay implementation of the MLR enrollment sanctions for contracts that fail to meet the MLR requirement for three consecutive contract years; that we develop a fixed quality improvement (QI) rate that could be added to the MLR numerator, similar to what is permitted under the commercial MLR regulations (45 CFR 158.221(b)(8)); that we provide guidance to plan sponsors concerning corrections of prior MLR submissions when errors are found that impact remittance calculations and that we develop a process to correct such data; and that we not apply the MLR requirements to standalone Part D plans. A commenter recommended that we mandate in the final rule that Part D sponsors must utilize a system to apply direct and indirect remuneration (DIR) fees at the point of sale as a means of improving the accuracy of the reported MLRs.

Response: We thank the commenters for their recommendations and will consider whether they are appropriate to address through future rule-making or other guidance.

After considering the comments we received and for the reasons outlined in the proposed rule and our responses to the comments, we are finalizing the proposal without modification.

3. Codifying Current Definitions of Partial, Full, and Non-Credibility and Credibility Factors (§§ 422.2440 and 423.2440)

The regulations at §§ 422.2440 and 423.2440 provide for the application of a credibility adjustment to the medical loss ratios (MLRs) of certain MA and Part D contracts with relatively low enrollment. A credibility adjustment is a method to address the impact of claims variability on the experience of smaller contracts by adjusting the MLR upward. As discussed in the February 2013 Medicare MLR proposed rule (78 FR 12438), for contracts with fewer members, random variations in the claims experience of enrollees could cause a contract's reported MLR to be considerably below or above the statutory requirement in any particular year, even though the MA organization or Part D sponsor estimated in good faith that the combination of the projected revenues and projected claims would produce an MLR that meets the statutory 85 percent minimum MLR requirement. The MLR credibility adjustments address the effect of this random variation by increasing the MLR of smaller contracts, thereby reducing the probability that such contracts will fail to meet the minimum MLR requirement simply because of random claims variability.

Whether a contract receives a credibility adjustment depends on the extent to which the contract has credible experience. A contract with credible experience is one that covers a sufficient number of beneficiaries for its experience to be statistically valid. A contract with fully credible experience has sufficient data to expect that the statistical variation in the reported MLR is within a reasonably small margin of error and will not receive a credibility adjustment under §§ 422.2440(b) and 423.2440(b). A contract has non-credible experience if it has so few beneficiaries that it lacks valid data to determine whether the contract meets the MLR requirement. Under §§ 422.2440(c) and 423.2440(c), a contract with non-credible experience is not subject to sanctions for failure to meet the 85 percent MLR requirement. A contract has partially credible experience if it exceeds the enrollment threshold for non-credible experience but does not have a sufficient number of enrollees for its experience to be fully credible. For contracts with partially credible experience, a credibility adjustment adds additional percentage points to the MLR in recognition of the statistical unreliability of the underlying data.

In the May 2013 Medicare MLR final rule (78 FR 31295 through 31296), CMS published the definitions of partial, full, and non-credibility and the credibility factors for partially credible MA and Part D contracts for contract year 2014. The factors appeared in that final rule in Tables 1A (finalized here as Table 1 to § 422.2440) and 1B to (finalized here as Table 1 to § 423.2440). Consistent with that final rule and regulations at §§ 422.2440 and 423.2440, for contract years 2015 through 2020, we finalized through the annual Advance Notice and Rate Announcement process the continued use of these definitions and credibility factors.

As explained in the proposed rule, we believe that the definitions of partial, full, and non-credibility and the credibility factors published in the May 2013 Medicare MLR final rule continue to appropriately address the effect of random claims variability on the MLRs of low enrollment MA and Part D contracts. However, we believe that it is more consistent with the policy and principles articulated in Executive Order 13892 on Promoting the Rule of Law Through Transparency and Fairness in Civil Administrative Enforcement and Adjudication (October 9, 2019) that we define and publish the definitions of partial, full, and non-credibility and the credibility factors in the **Federal Register**, and that we codify these definitions and factors in the Code of Federal Regulations, as opposed to defining and publishing these terms and factors through the annual Advance Notice and Rate Announcement process. Therefore, we proposed to amend our regulations at §§ 422.2440 and 423.2440 to codify the definitions of partial, full, and non-credibility and the credibility factors that we published in the May 2013 Medicare MLR final rule (78 FR 31296).

We proposed to amend paragraph (d) of §§ 422.2440 and 423.2440 by removing the current text (which states that CMS will define and publish definitions of partial, full, and non-credibility and the credibility factors through the annual Advance Notice and Rate Announcement process) and adding new paragraphs (d)(1) through (3) to specify ranges for the number of member months at which a contract's experience is, respectively, partially credible, fully credible, or non-credible. We proposed that the number of member months at which a contract's experience is defined as partially credible, fully credible, or non-credible be the same as the values that were used define each of those terms in the May 2013 Medicare MLR final rule. Thus, for MA contracts, we proposed that a contract is partially credible if it has at least 2,400 member months and fewer than or equal to 180,000 member months, fully credible if it has more than 180,000 member months, and non-credible if it has fewer than 2,400 member months. For Part D contracts, we proposed that a contract is partially credible if it has at least 4,800 member months and fewer than or equal to 360,000 member months, fully credible if it has more than 360,000 member months, and non-credible if it has fewer than 4,800 member months. We proposed to amend §§ 422.2440 and 423.2440 by removing from paragraphs (a) and (b) of both sections the text which indicates that CMS determines whether a contract's experience is partially credible or fully credible, respectively, and by adding at paragraphs (a), (b), and (c) of both sections new language specifying that partially credible experience is defined at (d)(1), fully credible experience is defined at (d)(2), and non-credible experience is defined at (d)(3).

At § 422.2440, we proposed to add new paragraph (e) to address the credibility adjustment for partially

credible contracts. We proposed at paragraph (e)(1) that, for partially credible MA contracts other than MSA contracts, the credibility adjustment is the base credibility factor determined under proposed paragraph (f). At new paragraph (f), we proposed to specify that the base credibility factor for a partially credible MA contract is determined based on the number of member months and the factors in Table 1 to § 422.2440. New paragraph (f) also states the rules for using Table 1 to § 422.2440 to identify the base credibility factor: (i) When the number of member months for a partially credible MA contract exactly matches the amount in the ''Member months'' column in Table 1 to § 422.2440, the value associated with that number of member months is the base credibility factor; and (ii) the base credibility factor for a number of member months between the values shown in Table 1 to § 422.2440 is determined by linear interpolation.

At § 423.2440, we proposed to add new paragraph (e), which provides that, for partially credible Part D contracts, the applicable credibility adjustment is determined based on the number of member months and the factors in Table 1 to § 423.2440. New paragraph (e) states the rules for using Table 1 to § 423.2440 to identify the base credibility factor: (1) When the number of member months used to determine credibility exactly matches a member month category listed in Table 1 to § 423.2440, the value associated with that number of member months is the credibility adjustment; and (2) the credibility adjustment for a number of member months between the values shown in Table 1 to § 423.2440 is determined by linear interpolation.

We received no comments on this proposal and are finalizing this provision without modification for the reasons outlined in the proposed rule.

4. Deductible Factor for MA Medical Savings Account (MSA) Contracts (§ 422.2440)

We proposed to include in the MLR calculation an additional adjustment factor for MA medical savings account (MSA) contracts that receive an MLR credibility adjustment. Specifically, we proposed that the credibility adjustment for partially credible MA MSA contracts will be calculated by multiplying the applicable base credibility factor in Table 1 to § 422.2440 by a ''deductible factor.'' This additional adjustment for MA MSAs is intended to recognize that the variability of claims experience is greater under health insurance policies with higher deductibles than under policies with lower deductibles, with high cost or outlier claims representing a larger portion of the overall claims experience of plans with high deductibles. As a result, a contract with a high average deductible is more likely to report a low MLR than is a contract with the same number of enrollees but with a low average deductible. As under the commercial MLR rules, the proposed deductible-based adjustment would only apply to contracts that receive a credibility adjustment due to low enrollment. We believe that a contract with experience that is fully credible has sufficient data to expect that the statistical variation in the reported MLR is within a reasonably small margin of error, regardless of the deductible level.

In the February 2013 Medicare MLR proposed rule (78 FR 12428), we explained that we used the commercial MLR rules as a reference point for developing the Medicare MLR rules. We sought to align the commercial and Medicare MLR rules in order to limit the burden on organizations that participate in both markets, and to make commercial and Medicare MLRs as comparable as possible for comparison and evaluation purposes, including by Medicare beneficiaries. However, we recognized that some areas of the commercial MLR rules would need to be revised to fit the unique characteristics of the MA and Part D programs. One way in which the Medicare MLR rules currently deviate from the commercial rules is the omission of a deductible-based adjustment to the Medicare MLR calculation. The rationale given in the February 2013 Medicare MLR proposed rule for omitting a deductible factor from the Medicare MLR calculation was that Medicare deductibles were more confined than deductibles in the commercial market, and that we believed that the limited range of Medicare cost sharing did not prompt the need for such an adjustment (78 FR 12439).

As explained in the proposed rule, although we continue to believe that deductibles for most MA and Part D contracts are too low to necessitate the adoption of a deductible factor for all contracts, we now recognize that the February 2013 Medicare MLR proposed rule's rationale for excluding a deductible factor from the Medicare MLR calculation did not adequately take into account the specific characteristics of MA MSA plans, which tend to have much higher deductibles than other MA plan types. For contract year 2020, the average deductible is $454 for MA plans (excluding MA MSAs) and $6,000 for MA MSAs. The proposed rule noted that, under the commercial MLR regulations at 45 CFR part 158, a deductible factor applies to the credibility adjustment of issuers of employer group and private health insurance plans that have an average deductible of $2,500 or higher. For contract year 2020, all MA MSAs have deductibles in excess of $2,500. These significantly higher deductibles in MSA plans cause MA MSA contracts to have more variability in their claims experience relative to MA contracts with the same number of enrollees but lower deductibles. In light of this information, we believe that it is clear that our policy of excluding a deductible factor for MA MSA contracts should be revisited.

Further, to the extent that this variability in claims experience and its potential impact on the MLR calculation has deterred MA organizations from offering an MSA product, the proposed addition of a deductible factor to the MLR calculation for MA MSAs would serve to encourage the offering of MA MSA plans by eliminating the current inconsistency in how the commercial and Medicare MLR rules take into account the greater variability of claims experience under health insurance policies with high deductibles. The proposed rule noted that our proposal to add a deductible factor to the MLR calculation for MA MSA contracts aligns with the directive in Executive Order 13890 on Protecting and Improving Medicare for Our Nation's Seniors (October 3, 2019) for the Secretary to take actions that ''encourage innovative MA benefit structures and plan designs, *including through changes in regulations and guidance that reduce barriers to obtaining Medicare Medical Savings Accounts . . . .*'' (emphasis added). The proposed rule also noted that, for many Medicare beneficiaries, the greatest barrier to enrolling in an MA MSA has been the lack of MA MSA plans in the beneficiary's area of residence. For contract year 2020, MA MSA plans are only available in 27 states and the District of Columbia. The omission of a deductible-based adjustment from the current Medicare MLR regulations could contribute to the limited availability of MA MSAs for Medicare beneficiaries because the greater variability in the MLR for contracts with high average deductibles—and the resulting higher risk of a potential remittance to CMS or sanctions under § 422.2410—could dissuade MA organizations from offering plans of this type. We noted in the proposed rule our belief that finalizing a deductible factor for MA

MSAs would make it less likely that MA organizations would be deterred from offering MA MSA plans out of concern that the MA MSA contract would be at risk of failing to meet the MLR requirement due to random variations in claims experience.

We proposed to adopt the same deductible factors that apply under the commercial MLR regulations at 45 CFR part 158. As noted in the December 1, 2010 Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act Interim Final Rule (75 FR 74881 through 74882), the commercial deductible factors were based on an actuarial analysis of anticipated claims experience in the commercial market by actuarial consultants to the National Association of Insurance Commissioners (NAIC). We explained in the proposed rule that we would prefer to use Medicare data to develop the deductible factors that apply to MA MSAs, and that we intend to assess the feasibility of using Medicare data for this purpose. We noted in the proposed rule and continue to believe that the commercial deductible factors are suitable for adjusting MSA MLRs in the absence of Medicare-specific deductible factors because the commercial factors are designed to take into account the variability in claims experience resulting from similarly high deductibles. We proposed to apply the commercial deductible factors in the MLR calculation for MA MSAs. We solicited comment on whether and how Medicare data should be used to evaluate whether the difference in variability between MLRs for MSA plans and non-MSA plans necessitates the use of Medicare-specific deductible factors, as well as how Medicare data could be used to develop Medicare-specific deductible factors. We also solicited comment on whether and how the proposed deductible factors should be adjusted to account for any unique features of the Medicare MLR rules (for example, the inclusion of the MA MSA deposit amount in the Medicare MLR numerator and denominator), or to reflect any differences between the commercial and Medicare MLR rules (such as the commercial rules' lower minimum MLR requirement for small group and individual health insurance plans (80 percent, compared to the Medicare rules' 85 percent MLR requirement for all contracts)). We solicited comment on potential consequences of the application of a deductible factor to the MLR calculation for MA MSA contracts, such as impacts on benefits for enrollees in MSA plans.

We proposed new § 422.2440(e)(2) to specify that the credibility adjustment for an MA MSA contract would be the base credibility factor determined under new paragraph (f), multiplied by the deductible factor determined under new paragraph (g). At new paragraph (g), we proposed to specify that the applicable deductible factor for an MA MSA contract would be based on the enrollment-weighted average deductible for all MSA plans under the contract, where the deductible for each plan under the contract is weighted by the plan's portion of the total number of member months for all plans under the contract during the contract year for which the MLR is being calculated. (We note that all MA plans under an MA MSA contract must be MSA plans, and MSA plans may only be offered under MSA contracts.) When the weighted average deductible for a contract exactly matches the amount in the ''Weighted average deductible'' column in Table 2 to § 422.2440, the value associated with that weighted average deductible is the deductible factor. The deductible factor for a weighted average deductible between the values shown in Table 2 to § 422.2440 is determined by linear interpolation.

We received 5 comments on the proposal to add a deductible factor to the MLR calculation for MA MSAs. The following is a summary of the comments we received on the proposal and our responses:

Comment: A commenter supported the proposal. The commenter expressed hope that adding a deductible factor to the MLR calculation for MA MSA contracts would lead to the greater availability of MA MSA products in the marketplace, which the commenter believed would be an attractive option for many consumers.

Response: We thank the commenter for their support.

Comment: A commenter stated that they do not support policies that single out high-deductible health plans for preferential MLR treatment for the purpose of encouraging beneficiaries to enroll in such plans.

Response: We appreciate the commenter's objection to MLR policies that favor certain plan types over others. However, we disagree with the commenter's characterization of the proposed application of a deductible factor to the MLR calculation for certain MSA contracts as a form of preferential treatment. As explained in the proposed rule and summarized here, we believe an additional adjustment to the MLR calculation for MSA contracts is appropriate because the variability of claims experience is greater under health insurance policies with higher deductibles than under policies with lower deductibles, with high cost or outlier claims representing a larger portion of the overall claims experience of plans with high deductibles. This is the case because high-deductible health plan enrollees' medical expenses must exceed a higher threshold before the plan begins to incur claims costs that can be included in the MLR numerator. As a result, a contract with a high average deductible is more likely to report a low MLR than is a contract with the same number of enrollees but a low average deductible. The deductible factor, which functions as a multiplier on the credibility adjustment factor, is calibrated so that the probability that a contract will fail to meet the MLR requirement is the same for all contracts that receive a credibility adjustment, regardless of the deductible level. Because the deductible factor is intended to mitigate the increased likelihood that a contract with a high deductible will fail to meet the MLR requirement due to random variations in claims experience, we believe that its application to the Medicare MLR calculation for MSA contracts serves to level the playing field for all MA contract types. We believe that the absence of a deductible factor from the current regulations unduly penalizes MSA contracts and that adding a deductible factor removes this potential deterrent to the offering of MSAs.

Comment: Three commenters opposed the proposal because they objected to CMS giving MA organizations an incentive to enroll beneficiaries in high deductible health plans such as MSAs. A commenter expressed concern that beneficiaries may enroll in these plans due to their low premiums and tax benefits, without realizing that they could be responsible for thousands of dollars of pre-deductible costs should they need significant medical attention. Another commenter warned that Medicare beneficiaries have limited incomes and frequently experience chronic conditions, the proliferation of high-deductible MSAs among this vulnerable population could have catastrophic effects on beneficiary health, as enrollees forego care to avoid paying high out-of-pocket costs. A couple of commenters cited research which suggests that although high deductible plans reduce costs, this may be attributable to a decrease in utilization of necessary medical services or to high

deductible plans enrolling younger, healthier members.

Response: We appreciate the commenters' concerns. Expanding access to MSAs so that Medicare beneficiaries who see the advantages in enrolling in a high-deductible plan have the option of doing so is a priority of the Trump administration. As discussed in the proposed rule, the proposal to add a deductible factor to the MLR calculation for MA MSA contracts aligns with the directive in Executive Order 13890 on Protecting and Improving Medicare for Our Nation's Seniors (October 3, 2019) for the Secretary to take actions that ''encourage innovative MA benefit structures and plan designs, *including through changes in regulations and guidance that reduce barriers to obtaining Medicare Medical Savings Accounts . . . .*'' (emphasis added).

We note that the research cited by the commenters is mostly based on the experience of enrollees in high-deductible health plans operating outside of the Medicare context. We believe that the widespread availability of zero premium MA plans makes it less likely that Medicare beneficiaries will enroll in high deductible plans due to the low premiums and tax benefits without adequately considering their potential out of pocket liability. In addition, there are protections to ensure that MSA enrollees have information that enables them to assess the coverage provided by MSA plans. Section 1852(c)(1)(B) of the Act and § 422.111(b)(2)(ii) require that MSA plans disclose, in clear, accurate, and standardized form to each enrollee at the time of enrollment and at least annually thereafter, a comparison of the benefits under the plan with benefits under other MA plans.

After consideration of the public comments we received and for the reasons outlined in the proposed rule and our responses to comments, we are finalizing the proposal without modification.

V. Codifying Existing Part C and D Program Policy

A. Medicare Advantage (MA) and Cost Plan Network Adequacy (§§ 417.416 and 422.116)

Section 1852(d)(1)(A) of the Act establishes that an organization offering an MA plan may select the providers from whom the benefits under the plan are provided so long as the organization makes such benefits available and accessible with reasonable promptness to each individual electing the plan within the plan service area. This is generally implemented at § 422.112(a), which provides that a coordinated care plan must maintain a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served. In the April 15, 2010, Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program Final Rule (75 FR 19691), CMS added criteria at § 422.112(a)(10) for determining whether an MA plan network is adequate and meets the statutory standard by codifying that MA plans must have networks that are consistent with the prevailing community pattern of health care delivery in the service area. The regulation provides that CMS will consider factors that make up the community patterns of health care, which CMS will use as a benchmark in evaluating MA plan networks, and lists certain examples of those factors in § 422.112(a)(10)(i) through (v). CMS explained in the October 22, 2009, Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs Proposed Rule (74 FR 54644) that it would develop an automated system for reviewing network adequacy based on the elements that define community patterns of health care delivery and that we would define through subregulatory guidance how CMS would operationalize these factors.

Since that time, CMS has routinely provided subregulatory guidance to MA organizations that defines how CMS measures and assesses network adequacy.[34] We built the Network Management Module (NMM) in HPMS to facilitate automated reviews of plan networks and to annually transmit information to MA plans about provider/facility specialty types that are subject to maximum time and distance standards, minimum number requirements, and other critical information needed for the network adequacy reviews. The NMM also gave existing MA organizations and new applicants to the MA program the opportunity to routinely test their networks against our standards. Currently, we require that organizations contract with a sufficient number of specified providers/facilities to ensure that 90 percent of the beneficiaries have access to at least one provider/facility of each specialty type within the published maximum time and distance standards. We update and refine the data and information that feed into network adequacy measures and perform analyses as needed. It is important that CMS ensure that MA organizations maintain an adequate network of contracted providers that are capable of providing medically necessary covered services to beneficiaries, both to ensure compliance with section 1851(d) of the Act and to protect beneficiaries. The network adequacy rules protect beneficiaries by ensuring that most, it not all, of the beneficiaries enrolled in a plan have access to providers within a reasonable time and distance from where the beneficiaries reside.

In this final rule, we are codifying existing network adequacy standards to provide MA organizations with a greater understanding of how CMS measures and assesses network adequacy by adding a new regulation at § 422.116. Specifically, we are codifying in § 422.116 the list of provider and facility specialty types subject to network adequacy reviews, county type designations and ratios, maximum time and distance standards, minimum number requirements, and exceptions. The regulation also addresses CMS's annual publishing of the Provider Supply file and Health Service Delivery (HSD) reference file to release updated numbers and maximums for these standards in subsequent years. The final regulation reflects modifications from our current network adequacy policy to further account for access needs in all counties, including rural counties, and to take into account the impact of telehealth providers in contracted networks. Section 1876(c)(4) of the Act imposes similar requirements for cost plans offered under section 1876 of the Act to make Medicare-covered services available and accessible to each enrollee with reasonable promptness when medically necessary. Under this authority, we are also amending § 417.416(e) to require 1876 cost organizations to also comply with the network adequacy standards described in § 422.116. A summary of our proposal follows.

1. General Provisions

We proposed in § 422.116(a) that each network-based MA plan demonstrate that it has an adequate contracted provider network that is sufficient to provide access to medically necessary covered services consistent with standards in section 1851(d) of the Act, the regulations at §§ 422.112(a) and 422.114(a), and the rules in new § 422.116. We also proposed that when required by CMS, an MA organization

[34] *See* ''Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance'' *https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.*

must attest that it has an adequate network for access and availability of a specific provider or facility type that CMS does not independently evaluate in a given year. We explained that we would require such attestation in the MA organization's application or contract for a given year, but we might require the attestation when performing other network adequacy reviews, such as when there is a significant change in the MA plan's provider network.

We cross-referenced § 422.114(a)(3)(ii) to identify the network-based plan types that would be subject to these network adequacy requirements. Network-based MA plans include all coordinated care plans in § 422.4(a)(1), network-based MA private-fee-for-service (PFFS) plans in § 422.4(a)(3), and 1876 cost organizations. Generally, network-based MA medical savings account (MSA) plans are considered coordinated care plans in accordance with § 422.4(a)(1)(iii)(D), which includes ''other network plans'' as a type of coordinated care plan. However, since MSA plans do not require contracted networks, we proposed to exclude MSA plans from the requirements in § 422.116. By cross-referencing § 422.114(a)(3)(ii), we carved out an MA regional plan that meets access requirements substantially through deemed contracting, so local and regional PFFS plans operating in CMS defined network areas must meet CMS network adequacy requirements at § 422.116.

We proposed, at paragraph (a)(2), to codify the general rule underlying § 422.116 that an MA plan must meet maximum time and distance standards and contract with a specified minimum number of each provider and facility specialty type, with each contract provider type within maximum time and distance of at least one beneficiary (in our MA Medicare Sample Census) in order to count toward the minimum number. The location of a contracted provider specialty or facility is not required to be within the county or state boundaries to be considered within the time and distance standards. The minimum number criteria and the time and distance criteria vary by the county type. We proposed to establish the specific provider and facility types; county types; specific time and distance standards by county designation; and specific minimum provider number requirements in paragraphs (b), (c), (d) and (e), respectively, of § 422.116. Regardless of whether CMS evaluates a plan's network against the access and adequacy standards in a given year, a plan's network must meet these standards and will be held to full compliance with the standards. At paragraphs (a)(3) through (4), we proposed to codify additional general rules about the network adequacy requirements in this section. At paragraph (a)(3), we proposed general rules for which provider types are not counted in evaluating network adequacy. In paragraph (a)(4), we proposed to codify certain administrative practices we have instituted over the past several years. Specifically, we proposed to annually update and make available Health Service Delivery (HSD) reference files in advance of our review of plan networks. These HSD files contain the minimum provider and facility number requirements, minimum provider ratios, and the minimum time and distance standards. We also proposed that we would annually update and make available a Provider Supply file that identifies available providers and facilities with office locations and specialty types. The Provider Supply file is updated annually based on information from the Integrated Data Repository (IDR), which has comprehensive claims data, as well as information from public sources. We may also update the Provider Supply file based on its findings from validation of provider information.

2. Provider and Facility Specialty Types

We proposed to codify at § 422.116(b) the list of provider and facility specialty types that have been subject to CMS network adequacy standards in the past, as not all specialty types are included in network adequacy reviews. We identified and proposed to codify the 27 provider specialty types and 14 facility specialty types that are currently used in the evaluation of network adequacy in each service area. We identified these provider and facility specialty types as critical to providing services based on review of Medicare FFS) utilization patterns, utilization of provider/facility specialty types in Medicare FFS and managed care programs, and the clinical needs of Medicare beneficiaries. We proposed to codify at § 422.116(a)(3) existing policy on the provider and facility types that are not counted in evaluating network adequacy: Specialized, long-term care, and pediatric/children's hospitals and providers and facilities contracted with the organization only for its commercial, Medicaid, or other non-MA plans. In paragraph (a)(3), we also proposed that hospital-based dialysis may count in network adequacy criteria for the facility type of Outpatient Dialysis. We clarified that primary care providers, the first provider specialty in our proposed list in paragraph (b)(1), are measured as a single specialty by combining provider specialty codes (001–006) in the HSD reference file.

Section 2005 of the SUPPORT Act establishes a new Medicare Part B benefit for Opioid Use Disorder treatment services furnished by Opioid Treatment Programs (OTPs) on or after January 1, 2020. OTPs provide medication-assisted treatment for people diagnosed with an Opioid Use Disorder and must be certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and accredited by an independent, SAMHSA-approved accrediting body. We did not propose to include OTPs as a facility type in § 422.116(b)(2) and explained it was due to the newness of the benefit and that we may consider adding OTPs to the facility type list in future proposals. However, we reminded MA organizations that they are required to pay for medically necessary care from certified OTPs.

We proposed at § 422.116(b)(3) that CMS may remove a specialty or facility type from the network adequacy evaluation for a particular year by not including the type in the annual publication of the HSD reference file. For example, in the past CMS removed oral surgery as a provider specialty type from the HSD reference file, and replaced home health and durable medical equipment with an attestation in its application about the plan's network ensuring access to providers of these types. We proposed at § 422.116(a)(1) to require an MA plan to submit an attestation when required by CMS. We explained that we would require an MA organization to complete an attestation that it has an adequate network that provides the required access to and availability of provider specialty or facility types even where we do not evaluate access ourselves. Network adequacy criteria are measured for each individual specialty type and do not roll up into an aggregate score. Therefore, the removal of a specialty type from the network review will not affect the outcome of an MA plan's network review and use of an attestation in lieu of evaluation will permit us some necessary flexibility. In light of the lack of change to the list we have used over the past several years, we did not propose any means for CMS to add new provider specialty or facility types to the network adequacy evaluation without additional rulemaking.

3. County Type Designations

We proposed at § 422.116(c) to codify our current policy regarding county designations. Network adequacy is

assessed at the county level, and counties are classified into five county type designations: Large Metro, Metro, Micro, Rural, or CEAC (Counties with Extreme Access Considerations). These metrics provide the means by which the various network adequacy criteria are differentiated to represent large geographic variations across the United States and its territories. They are based on the population size and the population density of each county.

We proposed to codify at § 422.116(c) the five county type designations using population size and density parameters that were identified in Table 6 in the proposed rule (85 FR 9094). Under our proposal, a county must meet both the population and density parameters for inclusion in a given county type designation and we explained that the proposed parameters are consistent with those we have used in conducting network adequacy reviews in prior years. We explained that we based the parameters on approaches used by the United States Census Bureau in its classification of ''urbanized areas'' and ''urban clusters,'' and by the Office of Management and Budget (OMB) in its classification of ''metropolitan'' and ''micropolitan.'' To calculate population density at the county level, we divided the latest county-level population [35] estimate by the land area [36] for that county. We also stated that our county designation methodology was designed specifically for MA network adequacy and may not be appropriate for other purposes.

4. Maximum Time and Distance Standards and Customization

We proposed in § 422.116(a)(2) that network adequacy is measured using both maximum time and distance standards and minimum number requirements that vary by county type. In § 422.116(d), we proposed that CMS determines maximum time and distance standards by county type and specialty type and publishes these standards annually in the HSD Reference file. Maximum time and distance standards are set by county designation, referred to as the ''base'' time and distance standards, or by a process referred to as ''customization.'' We proposed to codify the base time and distance standards by county designation that are in current practice with recent network reviews and included the standards in Table 7 of the proposed rule (85 FR 9095) as well as in the proposed regulation text as Table 1 to paragraph (d)(2). We also explained in greater detail how the specific time and distance standards we proposed for each provider and facility type and county designation were developed and refer readers to the proposed rule for that discussion (85 FR 9097).

As explained in the proposed rule, we have added flexibility in recent years to expand the time (in minutes) and distance (in miles) standards beyond the base standards in cases where, due to a shortage of supply of providers or facilities, it is not possible to meet the base time and distance standards. We proposed to codify this flexibility and the process for using it at § 422.116(d)(3) and refer to it as ''customization.'' To customize distance standards, we use software to map provider location data from the Provider Supply file against the population distribution data in CMS's MA Medicare Sample Census.[37] For each specialty and county where there are insufficient providers within the base distance standard, we use mapping results to identify the distance at which 90 percent of the population would have access to at least one provider or facility in the applicable specialty type. The resulting distance is then rounded up to the next multiple of five (51.2 miles would be rounded up to 55 miles), and a multiplier specific to the county designation is applied to determine the analogous maximum time criterion. We requested comment on our customization methodology and whether we should adjust factors in the distance calculation to achieve outcomes that are more equitable.

Customization of base criteria may be triggered based on information received through exception requests from plans, or from other sources, such as certificates of need (CON) from state departments of health. However, we proposed that CMS may only use customization to increase time and distance standards from the base standards, and may not reduce time and distance standards below the base standards. We solicited comment from the industry on other sources of information that CMS should consider and how it would work within the structure of our network adequacy standards.

Historically, we have required that at least 90 percent of the beneficiaries residing in a particular county have access to at least one provider/facility of each specialty type within the published maximum time and distance standards for that county. In an effort to encourage more MA offerings in rural areas, we proposed to reduce this percentage to 85 percent in Micro, Rural, and CEAC counties. In these generally ''rural'' counties, there is evidence of a lower supply of physicians, particularly specialists, compared to urban areas.[38] In order to account for this shortage, two state Medicaid programs that utilize network adequacy criteria have adjusted percentages in rural counties to require that standards be met for less than 100 percent of enrollees. New Jersey allows an 85 percent coverage requirement for primary care in ''non-urban counties'' but 90 percent in urban counties.[39] Tennessee's Medicaid managed care program takes a slightly different approach, requiring that 60 percent of enrollees have access within 60 miles and 100 percent within 90 miles.[40] Additionally, the Part D program has a 90 percent retail pharmacy network coverage requirement in urban and suburban areas that drops to 70 percent for rural areas.[41] Further, our data indicates that existing failures in MA plans' meeting the time and distance standards frequently occur at the range between 80 to 89 percent of beneficiaries. As a result, we proposed to adopt a similar change in our MA network adequacy approach to account for access challenges in Micro, Rural,

[35] United States Census Bureau. American Factfinder. Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018: 2018 Population Estimates. Retrieved from: *https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2017_PEPANNRES&src=pt.*

[36] United States Census Bureau. American Factfinder. Population, Housing Units, Area, and Density: 2010—United States—County by State; and for Puerto Rico: 2010 Census Summary File 1. Retrieved from: *https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_SF1_GCTPH1.US05PR&prodType=table.*

[37] CMS built the MA Medicare Sample Census, which derives from information maintained by CMS on the residence of Medicare beneficiaries. CMS built the Sample Census to be an adequate representative sample of Medicare beneficiaries in each applicable county. This file is only available to CMS and is only utilized for the purposes of measuring network adequacy.

[38] Department of Health and Human Services, National Advisory Committee on Rural Health and Human Services (2018) ''Rural Health Insurance Market Challenges: Policy Brief and Recommendations.'' Retrieved April 3, 2019, from: *https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2018-Rural-Health-Insurance-Market-Challenges.pdf.*

[39] State of New Jersey Dept. of Human Services. ''Contract Between State of New Jersey Department of Human Services Division of Medical Assistance and Health Services and _____, Contractor'' Sec. 4.8.8 ''Provider Network Requirements'' Retrieved April 5, 2019, from: *https://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf.*

[40] State of Tennessee, Department of Finance and Administration, Division of Health Care Finance and Administration, Division of TennCare (2019) ''Statewide Contract with Amendment 9—January 1, 2019'' Attachment IV. Retrieved April 3, 2019, from: *https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf.*

[41] Section 423.120(a)(1.).

and CEAC counties; at § 422.116(d)(4)(i) we proposed that at least 85 percent of the beneficiaries have access to at least one provider/facility of each specialty type within the published time and distance standards in Micro, Rural, and CEAC counties. We estimated that approximately 14 percent of contracts (96 contracts) operating in these county designations will benefit from the reduced percentage and will no longer need to submit an exception request. We proposed to codify the existing policy of using a 90 percent threshold for Large Metro and Metro counties in § 422.116(d)(4)(ii). We noted that this specific proposal did not include a change from current policy requirements for a minimum number of provider specialties and facilities and that we proposed, at paragraph (e), that MA plans would still be required to maintain contracts with a minimum number of providers in each county.

We also proposed to give an MA plan a 10-percentage point credit towards the percentage of beneficiaries residing within the applicable time and distance standards for certain provider specialty types when the plan contracts with telehealth providers for those specified specialty types. For example, in a rural county where an MA plan must have 85 percent of beneficiaries residing within applicable time and distance standards, the MA plan would receive an additional 10 percentage points towards the 85 percent requirement should they contract with applicable telehealth providers under § 422.135. We explained that this is not currently part of the network adequacy evaluation, but we believed it is appropriate in light of the expanding coverage in the MA program of additional telehealth benefits. In the April 2019 final rule, we adopted § 422.135 to implement the option for MA plans to offer additional telehealth benefits as part of their coverage of basic benefits under section 1852(m) of the Act, as amended by section 50323 of the BBA of 2018. In that rulemaking, we solicited feedback from the industry concerning the impact, if any, that telehealth should have on network adequacy policies. We received approximately 35 responses from stakeholders in managed care, provider, advocacy, and government sectors. While health plans clearly favored taking into account telehealth access while evaluating network adequacy, providers had more concerns that telehealth services could be used to replace, rather than supplement, in-person healthcare delivery. A commenter stated that it is imperative that beneficiaries continue to have the choice to access services in-person not only as a matter of preference, but to ensure those that do not have access to the required technologies are not left without care. Section 1852(m)(4) of the Act and the regulation at § 422.135(c)(1) require that an enrollee in an MA plan offering additional telehealth benefits must retain the choice of receiving health care services in person rather than through electronic exchange (that is, as telehealth). With that in mind, and emphasizing the importance of maintaining an in-person network, we did not propose any changes to how we currently calculate minimum provider requirements and MA plans would still contract with a minimum number of providers for each specialty type. We explained that we believed this is imperative for MA plans to be able to provide in-person care when needed or when preferred by the beneficiary and that contracting with telehealth providers as a supplement to an existing in-person contracted network would give enrollees more choices in how they receive health care. Further, we explained that it is important and appropriate to account for contracted telehealth providers in evaluating network adequacy consistent with reflecting how MA plans supplement, but do not replace, their in-person networks with telehealth providers. We proposed, at § 422.116(d)(5) to provide a 10-percentage point credit towards the percentage of beneficiaries residing within time and distance standards for specific provider specialty types by county when the MA plan includes one or more telehealth providers that provide additional telehealth benefits, as defined in § 422.135, in its contracted network. Since additional telehealth benefits described at § 422.135 only apply to MA plans, cost plans would not be eligible for this 10-percentage point credit under proposed § 417.416(e)(3).

We explained that a 10-percentage point credit is an appropriate amount that proportionately supplements a plan's percentage score because telehealth providers add value to a contracted provider network, but should not have the same level of significance or value as an in-person provider. Additionally, we noted how information from prior network adequacy reviews show that many failures in meeting time and distance standards occur in this 80 to 89 percent range. Therefore, we stated, a 10-percentage point credit is significant enough to have an impact on MA plans and encourage the use of telehealth, while being proportionate to the role that telehealth providers have in a contracted network. Further, we proposed to apply this telehealth credit only to five specific provider specialty types: Dermatology, psychiatry, neurology, otolaryngology and cardiology. We explained that this limited approach would allow CMS to monitor the effectiveness of the credit, while also allowing us to determine whether there may be access or quality of care impacts. As we discussed in the April 2019 final rule, additional telehealth benefits are monitored by CMS through account management activities, complaint tracking and reporting, and auditing activities. These oversight operations will alert CMS to any issues with access to care and CMS may require MA organizations to address these matters if they arise.

We explained how we identified the five provider types for this proposal. CMS considered previous input from industry stakeholders, publicly available studies, and analyses of Medicare claims data for telehealth services in determining applicable provider specialty types. We considered not only the potential that telehealth has within a specialty type, but also the observed access challenges for provider specialty types over the years of our network adequacy reviews. In our experience, most MA plans do not have challenges meeting time and distance standards for primary care as compared to non-primary care provider specialty types. We also stated that it is critical to quality health care that Medicare beneficiaries have a primary care provider that they can visit in person and within a suitable time and distance. Therefore, despite the potential and prevalence of telehealth for furnishing primary care services, we did not believe that it was necessary to take telehealth access into account when measuring and setting minimum standards for access to primary care providers. We solicited comments on the provider specialty types we proposed to be eligible for the telehealth credit and whether CMS should expand or limit this credit to a different set of provider specialties.

In the proposed rule, we explained that we had received comments from providers and physician groups about the limitations of current network adequacy policies on dialysis treatment when performed in a hospital, at home, or in an outpatient facility. Some research suggested that home-based dialysis may offer advantages over in-center hemodialysis, including patient convenience, reduction in costs associated with dialysis, and potentially improved patient quality of life and blood pressure control with greater

survival and fewer hospitalizations.[42] We acknowledged in the proposed rule that there is more than one way to access medically necessary dialysis care and stated that we wanted plans to exercise all of their options to best meet a beneficiary's health care needs. We solicited comment on: (1) Whether CMS should remove outpatient dialysis from the list of facility types for which MA plans need to meet time and distance standards; (2) allowing plans to attest to providing medically necessary dialysis services in its contract application (as is current practice for DME, home health, and transplant services) instead of requiring each MA plan to meet time and distance standards for providers of these services; (3) allowing exceptions to time and distance standards if a plan is instead covering home dialysis for all enrollees who need these services; and (4) customizing time and distance standards for all dialysis facilities.

Additionally, we explained that CMS had received comments concerning patterns of provider consolidation and its impact on higher costs for patients. We received feedback from stakeholders that providers in concentrated areas may leverage network adequacy requirements in order to negotiate prices well above Medicare FFS rates. We solicited comment on existing problems and behavior in non-rural, consolidated provider markets and recommendations that we could take to encourage more competition in these markets.

We also proposed a policy to incorporate consideration of Certificate of Need (''CON'') laws into our network evaluations, as a modification from our current policy after a brief summary of the topic. President Trump's Executive Order 13890 on Protecting and Improving Medicare for Our Nation's Seniors (October 3, 2019) calls for adjustments to network adequacy requirements to account for the competitiveness of state health care markets, including taking into account whether states maintain CON laws or other anticompetitive restrictions. Many states began adopting CON laws in the 1960s and 1970s in part to promote resource savings and to prevent investments that could raise hospital costs.[43] A number of studies have found no evidence that CON programs have led to resource savings, and in some instances, may raise health care costs. In one study published in 2013, researchers studied whether states that dropped CON programs experienced changes in costs or reimbursements from coronary artery bypass graft surgery or percutaneous coronary interventions.[44] In this study, the cost savings from removing the CON requirements slightly exceeded the total fixed costs of new facilities that entered after deregulation. Another study published in 2016 concluded that there is no evidence that CON requirements limit health care price inflation and little evidence that they reduce health care spending.[45] It further concluded that CON laws are associated with higher per unit costs and higher total healthcare spending. Most relevant here, other studies suggest that the removal of these laws that serve as a barrier to entry into the market lead to greater access to providers and a redistribution of health care services to higher quality providers, improving the overall quality of health outcomes.[46]

After listing this research, we stated that it pointed out that CON laws restrict the supply and competition for healthcare services and increases costs and that CON laws adversely affect access in states and counties where they are in effect, including for MA organizations that operate in those areas. CMS pays MA organizations a capitated amount in each county for the provision of Medicare benefits based on the expected costs to provide benefits. When MA organizations must pay more for benefits, as the research demonstrates happens when there are fewer providers or facilities with which to contract, that reduces the access to benefits offered by MA organizations. In order to take into account the adverse effects that CON laws have on access, we proposed in § 422.116(d)(6) to provide that MA organizations may receive a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards for affected provider and facility types in states that have CON laws, or other state imposed anticompetitive restrictions, that limit the number of providers or facilities in a county or state. In the proposed rule, we explained that, where appropriate, CMS may instead address network adequacy by customizing base time and distance standards in states with CON laws. We explained that the proposal was justified based on the studies cited that have shown that CON laws adversely affect competition and free market entry in states and that our network adequacy policy thus should provide for us to consider this factor when evaluating the adequacy of an MA organization's contracted network.

We proposed to make this credit equal to and in addition to, if applicable, the proposed telehealth credit (10 percentage points) for reasons similar to those for the telehealth credit policy: Information from prior network adequacy reviews show that many failures in meeting time and distance standards occur in the 80 to 89 percent range. We explained that, under our proposal, CMS could elect to grant this credit instead of customizing time and distance standards depending on a number of factors, like the speed of implementing customized standards, operational and timing constraints, and the amount of work required to calculate customized time and distance standards. We solicited comment on additional criteria or factors we should consider when deciding whether to apply the 10-percentage point credit or customize time and distance standards in the impacted states or counties. Additionally, we solicited comment about what other actions CMS could take in markets with state CON laws.

We also considered whether there are circumstances where a more limited application of network adequacy flexibility might be more appropriate. We solicited comment as to how and under what circumstances we should refrain from applying the 10 percentage point credit, should mitigate the size of this credit, or other actions we might undertake to apply this flexibility in a more limited manner.

5. Minimum Number Standards

We proposed to codify the current policy that MA plans must contract with a specified minimum number of each provider and facility specialty type in § 422.116(e). The MA plan must have a minimum number of in-person providers and facilities in each county for each specialty type specified in paragraph (b). We explained the general rules at § 422.116(e)(1) that the provider or facility must be within the maximum time and distance of at least one beneficiary in order to count towards the minimum number requirement and cannot be a telehealth-only provider. We also proposed to codify the

[42] Comparative Effectiveness of Home-Based Kidney Dialysis Versus In-Center or Other Outpatient Kidney Dialysis Locations—A Systematic Review [internet]: *https://www.ncbi.nlm.nih.gov/books/NBK344417/.*

[43] Daniel Sherman, ''The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis,'' *Federal Trade Commission,* January 1988.

[44] Vivian Ho, Meei-Hsiang Ku-Goto, ''State Deregulation and Medicare Costs for Acute Cardiac Care,'' *Med Care Res Rev.,* April 2013.

[45] Matthew D. Mitchell, ''Do Certificate-of-Need Laws Limit Spending?'' *Mercatus Working Paper,* Mercatus Center at George Mason University, Arlington, VA, September 2016.

[46] David M. Cutler, Robert S. Huckman, and Jonathan T. Kolstad, ''Input Constraints and the Efficiency of Entry: Lessons from Cardiac Surgery,'' *American Economic Journal: Economic Policy,* February 2010.

methodology for establishing the minimum number requirements for specific contracted provider and facility specialty types per county. We explained that CMS would use this methodology each year to determine and publish the updated minimum provider standards on an annual basis and that certain standards for the minimum number of providers are updated annually to account for changes in the Medicare population, MA market penetration, and county designations. Our proposal required the provider/facility to be within the maximum time and distance of at least one beneficiary in order to count towards the minimum number requirements. We noted that the location of a contracted provider specialty or facility is not required to be within the county or state boundaries to be considered within the time and distance standards.

We proposed to codify at § 422.116(e)(2)(iii), our existing practice that all facilities, except for acute inpatient hospitals facilities, have a minimum number requirement of one. We limited the methodology for establishing and changing the required minimum number standard to acute inpatient hospitals and other non-facility provider specialties. We proposed the methodology at § 422.116(e)(3): CMS determines the minimum number requirement for all provider specialty types and Acute Inpatient Hospitals by multiplying the ''minimum ratio'' by the ''number of beneficiaries required to cover,'' dividing the resulting product by 1,000, and rounding up to the next whole number. The steps and components of the methodology were proposed in paragraphs (e)(3)(i) and (ii) and explained in the preamble of the proposed rule.

The Minimum Ratio is the number of providers required per 1,000 beneficiaries, and for Acute Inpatient Hospitals, the number of beds per 1,000 beneficiaries. We stated that CMS had established minimum ratios in 2011 using a number of data sources, including, Medicare fee-for-service claims data, American Medical Association (AMA) and American Osteopathic Association (AOA) physician workforce data, U.S. Census population data, National Ambulatory Medical Care Survey data, AMA data on physician productivity, and published literature. We proposed to codify those minimum ratios in the regulation at § 422.116(e)(3)(i) and reproduced it in the preamble as Table 13. (85 FR 9101)

We stated that the Number of Beneficiaries Required to Cover is also calculated by CMS based on an established methodology. The Number of Beneficiaries Required to Cover is the minimum population that an MA plan's network should be able to serve and represents the potential number of beneficiaries an organization may serve within a county. We proposed at § 422.116(e)(3)(ii)(A) that the Number of Beneficiaries Required to Cover is calculated by multiplying the ''95th Percentile Base Population Ratio'' times the total number of Medicare beneficiaries residing in a county. We explained that CMS uses its MA State/County Penetration data to calculate the total number of Medicare beneficiaries residing in a county. For counties with lower populations, and particularly for specialties with lower minimum ratios, the minimum number is usually one.

We proposed to continue the current policy of calculating the 95th Percentile Base Population Ratio annually for each county type. We explained in the proposed rule that CMS has previously allowed MA organizations to provide their expected enrollment and then define their networks based on that number, but had later developed and implemented a more objective means to measure network adequacy for all MA plans consistently. Based on our position that the 95th Percentile Base Population Ratio is a fair and consistent enrollment estimate that can be applied to new and current plans, we proposed to codify its continued use. While it varies over time as MA market penetration and plan enrollment changes across markets, the 95th Percentile Base Population Ratio currently ranges between 0.073 and 0.145 depending on county type, indicating that MA plans are expected to have networks at least sufficient to cover between 7.3 percent (Large Metro) and 14.5 percent (CEAC) of the Medicare beneficiaries in the county. This ratio represents the proportion of Medicare beneficiaries enrolled in the 95th percentile MA plan (that is, 95 percent of plans have enrollment lower than this level). We explained in the proposed rule how to calculate the 95th Percentile Base Population Ratio. We use the List of PFFS Network Counties [47] to exclude PFFS plans in non-networked counties [48] from the calculation at the county type level. We use the MA State/County Penetration data [49] to determine the number of eligible Medicare beneficiaries in each county, and our Monthly MA Enrollment data [50] to determine enrollment at the contract ID and county level, including only enrollment in RPPO, LPPO, HMO, HMO/POS, healthcare prepayment plans under section 1833 of the Act, and network PFFS plan types. We calculate penetration at the contract ID and county level by dividing the number of enrollees for a given contract ID and county by the number of eligible beneficiaries in that county. Finally, we group counties by county designation to determine the 95th percentile of penetration among MA plans for each county type. We proposed to codify the methodology for calculating the 95th Percentile Base Population Ratio at § 422.116(e)(3)(ii)(B).

6. Exceptions

Finally, we also proposed to codify in paragraph (f) a process by which an MA plan may request and receive an exception from the network adequacy standards in § 422.116. Under our current policy, CMS conducts network adequacy reviews through an automated process, but also allows for exceptions to that process when failures are detected in the submitted network. We proposed to codify the exceptions process, the basis upon which an MA plan may request an exception, and the factors that CMS may consider when evaluating an MA organization's request for an exception to the standards in § 422.116. We proposed that an MA organization may request an exception when two criteria are met: (1) Certain providers or facilities are not available for the MA organization to meet the network adequacy criteria as shown in the Provider Supply file for the year for a given county and specialty type, and (2) the MA organization has contracted with other providers and facilities that may be located beyond the limits in the time and distance criteria, but are currently available and accessible to most enrollees, consistent with the local pattern of care. For example, certain providers/facilities may not be available for contracting when the provider has moved or retired, or when the provider/facility does not contract with any

[47] CMS. PFFS Plan Network Requirements. Retrieved from: *https://www.cms.gov/Medicare/Health-Plans/PrivateFeeforServicePlans/NetworkRequirements.html.*

[48] Non-networked counties in this context means there are not at least two networked plans operating in that county.

[49] CMS. MA State/County Penetration. Retrieved from: *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-State-County-Penetration.html.*

[50] CMS. Monthly MA Enrollment by State/County/Contract. Retrieved from: *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-MA-Enrollment-by-State-County-Contract.html.*

organizations or exclusively with another organization. We proposed that we would implement and interpret the regulation such that the MA plan would have to contract with telehealth providers, mobile providers, or providers outside the time and distance standards, but accessible to most enrollees (or consistent with the local pattern of care), in order for the MA plan to request an exception by CMS. In evaluating exception requests, CMS proposed that it would consider: (i) Whether the current access to providers and facilities is different from the HSD reference and Provider Supply files for the year; (ii) whether there are other factors present, in accordance with § 422.112(a)(10)(v), that demonstrate that network access is consistent with or better than the original Medicare pattern of care; and (iii) whether approval of the exception is in the best interests of beneficiaries. These three criteria were proposed to be codified at paragraph (f)(2)(i), (ii) and (iii).

Currently, CMS collects information for purposes of testing an MA organization's network adequacy using the PRA-approved collection titled, ''Triennial Network Adequacy Review for Medicare Advantage Organizations and 1876 Cost Plans, CMS–10636, OMB 0938–1346.'' [51] CMS relies on this collection of information to evaluate whether an MA organization maintains a network of appropriate providers and facilities that is sufficient to provide adequate access to covered services based on the needs of the population served. In the PRA package, CMS explained that organizations must comply with the current CMS network adequacy criteria posted in the HSD reference file on CMS's website and updated annually. We proposed to codify the standards in order to formalize the use of criteria posted in the HSD reference file by codifying and explaining the standards and, where necessary, the formulas used to calculate network adequacy standards (that is, provider/facility types, maximum time and distance standards, minimum provider/facility numbers). We proposed that CMS would continue to use the HSD reference file as a means to communicate these standards to MA organizations and that we anticipated that there would be no updates or changes required to the approved collection of information for CMS to assess network adequacy. We stated in the proposed rule how the codified provisions would not impose any new or revised information collection requirements (that is, reporting, recordkeeping, or third-party disclosure requirements) or burden. We confirm here that these provisions are not subject to the PRA.

We thank commenters for their input to help inform our final rule on network adequacy policies. We received the following comments on this proposal, and our response follows:

Comment: A number of commenters gave feedback regarding the provider and facility specialty type lists in § 422.116(b). Some commenters suggested that CMS add provider specialty types for physical therapist, occupational therapist, transplant providers, psychologists, clinical social workers, nurse specialists, emergency physicians, and optometry. A few commenters suggested that CMS add transplant centers and inpatient rehabilitation hospitals and units to the list of facility specialty types.

Response: We appreciate the many viewpoints and recommendations on this subject. The regulation at § 422.112(a) require that MA organizations must ensure that all covered services are available and accessible under the plan. Further, MA organizations must maintain a network of providers to provide adequate access to covered services and must make arrangements for care outside the plan provider network, at in-network cost-sharing, when network providers are unavailable. As a result of this critical protection, we do not require that all provider and facility specialties be subject to network adequacy standards. In past network adequacy reviews, we have not evaluated every possible provider type that may provide a Medicare covered benefit in our network reviews. We also have not evaluated provider subspecialties, especially those that are extremely specialized in nature. We ensure access to all Medicare covered services through monitoring and investigating complaints in the CMS Complaint Tracking Module. We identify which provider and facility specialty types are critical and necessary to evaluate separately based on a review of Medicare FFS utilization patterns, utilization of provider/facility specialty types in Medicare FFS, specialties in other managed care programs, and the clinical needs of Medicare beneficiaries. For example, we consider the utilization rate of specific provider types in order to determine if it justifies the effort of developing specific standards, collecting data from plans, and analyzing the information. Therefore, we proposed to codify network adequacy standards for the 27 provider specialty types and 14 facility specialty types that are currently used in the evaluation of network adequacy in each service area and have well-established base time and distance standard associated with them. We emphasize that MA enrollees are entitled to access to all medically necessary services from Medicare participating providers and facilities whether or not the provider or facility type is subject to specific network adequacy standards under § 422.116.

Comment: In response to our identification of other options we were considering regarding outpatient dialysis centers, many commenters supported removing outpatient dialysis from the list of facility specialty types, and instead, requiring an attestation in its contract application. These commenters explained that this change would drive patient-centered innovation in dialysis treatment, encourage competition, and bring down high reimbursement costs for dialysis treatment. They also pointed out that this change would be consistent with how CMS monitors and ensures beneficiary access to durable medical equipment, home health care, and transplant services. Commenters suggested that the use of an attestation would ensure patient protection while also giving plans the flexibility they need to expand the delivery of innovative solutions to beneficiaries with End Stage Renal Disease (ESRD) requiring dialysis treatment. A few commenters that supported the removal of outpatient dialysis also suggested that providing exceptions for plans covering home dialysis for all beneficiaries who need such services or customizing time and distance standards for dialysis facilities would also improve the proposal.

On the other hand, many commenters recommended that CMS finalize its proposal and maintain maximum time and distance standards for outpatient dialysis centers without change. These commenters raised concerns that the removal of outpatient dialysis as a facility type would result in the discrimination of ESRD patients by MA plans because the network design would discourage patients with ESRD from enrolling. A few commenters believed that the removal of outpatient dialysis centers from the list of facility and specialty types for which we would use specific standards would conflict with the intent of the 21st Century Cures Act, which allows ESRD patients to enroll in MA plans in 2021. Some commenters raised access to care concerns and pointed out barriers to home dialysis,

[51] *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10636.*

such as housing insecurity and a lack of caregiver support, and others explained the need to have both home dialysis and in-center dialysis options of care and to leave the treatment choice in the hands of the patient. Lastly, a couple commenters did not believe that CMS provided adequate notice in the proposed rule to make any changes to outpatient dialysis in the final rule.

Response: In our proposal, we explained that we believed that there is more than one way to access medically necessary dialysis care and we sought to improve our network adequacy standards as they relate to measuring and setting minimum standards for access to dialysis services. We do not agree with commenters that the removal of outpatient dialysis facilities will result in network designs that discriminate against or discourage ESRD beneficiaries from enrolling in MA plans. Regardless of whether a facility or provider specialty type is subject to network adequacy standards, MA organizations are required in § 422.112(a)(3) to arrange for health care services outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical needs. Section 422.112(a)(10) requires MA plans to ensure access and availability to covered services consistent with the prevailing community pattern of health care delivery in the areas served by the network. The factors making up community patterns of health care delivery that CMS considers when evaluating an MA plan network—and which continue to apply regardless whether a specific time and distance or minimum number requirement is established pursuant to § 422.116 for a provider specialty or facility type—are at § 422.112(a)(10). For example, for any provider or facility types that are not included in network adequacy standards at § 422.116, CMS may consider the number and geographical distribution of eligible health care providers available to potentially contract with an MA organization to furnish plan covered services within the service area when deciding if MA plans meet access and availability requirements. Additionally, we may consider the prevailing market conditions in the service area of the MA plan and, more specifically, the number and distribution of health care providers contracting with other health care plans (both commercial and Medicare) operating in the service area of the plan. Therefore, if network providers are incapable of meeting the enrollee's medical needs because the burden of travel to the in-network dialysis center is inconsistent with the prevailing community pattern of health care delivery in the area, the MA plan must arrange for care outside of the network and at in-network cost-sharing in order to meet the MA plan's obligation under the MA program rules to furnish covered services. The network adequacy maximum time and distance standards proposed at § 422.116 are one way that we quantify prevailing patterns of health care delivery in areas, but it is not the only way to evaluate a network, as § 422.112(a)(10) provides. Most importantly, it does not mean that MA organizations do not need to maintain an adequate contracted network of contracted providers simply because a provider or facility type is not included in the network adequacy standards at § 422.116. MA organizations must maintain a network of contracted providers that is sufficient to provide adequate access to covered services to meet the needs of the population served and is consistent with the prevailing community pattern of health care delivery in the areas where the network is being offered. This critical beneficiary protection ensures that MA enrollees have similar reasonable access to providers and facilities as beneficiaries in FFS Medicare. Therefore, we believe that MA plans will continue to provide adequate access to dialysis providers. We disagree with commenters that believe that the removal of outpatient dialysis from the list being finalized in § 422.116 of facility types that are separately evaluated on time and distance and minimum number standards would necessarily lead to discrimination against ESRD patients or would conflict with the intent of the 21st Century Cures Act. The 21st Century Cures Act removed the prohibition against beneficiaries with ESRD from enrolling in an MA plan effective for plan years beginning on or after January 1, 2021. MA organizations must abide by all existing legal and regulatory anti-discrimination requirements, which include prohibitions on discrimination on the basis of health status, for any beneficiaries with ESRD enrolling in an MA plan.

For CMS performance data collected for Part C Star Ratings, CMS surveys beneficiaries on the ease of getting needed care and seeing specialists, as well as getting appointments and care quickly, through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey questions. MA organizations are incentivized by CMS Star Ratings policies to maintain high-star ratings by scoring well on these types of survey measures. Further, if beneficiaries believe that an MA organization is discriminating against them, complaints may be submitted into the Complaint Tracking Module (CTM). We monitor and investigate complaints related to access concerns and work with regional office caseworkers to resolve any issues with the MA organizations. We would take compliance or enforcement actions against an MA organization for failing to provide adequate access to medically necessary services, as warranted.

Also, we do not believe that the removal of outpatient dialysis as a facility type would cause access to care concerns. As we pointed out, MA organizations must maintain a contracted network that is sufficient to provide adequate access to covered services, and this includes the ability for enrollees to receive care in-person at an outpatient dialysis facility. We agree with commenters that this change will drive patient-centered treatment in dialysis services, which is at the heart of our intent in considering this change in policy. While we proposed to codify maximum time and distance standards for the facility type outpatient dialysis, we also solicited comments about four options to improve measuring and setting standards for access to dialysis services because we wanted MA plans to use more than one treatment modality to address access to dialysis services: (1) Removing outpatient dialysis from the list of facility types with specific evaluation standards; (2) allowing plans to attest to providing medically necessary dialysis services in its contract application (as is current practice for DME, home health, and transplant services); (3) allowing exceptions to time and distance standards if a plan is instead covering home dialysis for all enrollees who need these services; and (4) customizing time and distance standards for all dialysis facilities. We believe that by eliminating the outpatient dialysis facility type from the list in § 422.116(b)(2), MA organizations have the freedom to enhance their networks by contracting with dialysis providers that offer dialysis treatment through home-based modalities. These home based modalities give enrollees flexibility and control over their lives so that enrollees can choose the treatments that best meet their needs. We agree with commenters and understand that beneficiaries undergoing dialysis treatment often face changes in circumstances that may warrant movement from one modality to another. We believe this further

supports our intent to encourage MA organizations to establish networks that provide the most advanced and available treatment options to Medicare beneficiaries.

We also agree with commenters that the removal of outpatient dialysis from the list of facilities for which there are specific time and distance and minimum provider standards could encourage greater competition in dialysis treatment and treatment modalities, which will eventually lead to lower costs for Medicare beneficiaries without resulting in the denial of, or access to, lesser care. The removal of outpatient dialysis as a facility type from our network adequacy standards allows all dialysis treatments to be treated equally, which will encourage MA organizations to contract with facilities that offer different forms of dialysis treatments, rather than just dialysis at an outpatient facility. We believe this increased competition among treatment modalities could drive down plan and patient costs for dialysis services. We do not believe that creating exceptions related to home dialysis or customizing time and distance standards will bring about the same level of change that CMS is seeking. CMS will continue to oversee the provision of dialysis services through its monitoring efforts to ensure that MA beneficiaries have access to medically necessary care that meets their needs. We routinely monitor access to care complaints and impose compliance or enforcement actions, when necessary, to hold MA organizations accountable for the provision of all medically necessary covered services.

Lastly, a few commenters did not believe that CMS provided adequate notice and sufficient detail in the proposed rule for the alternative that we are finalizing here. We disagree and believe that our proposal and continued consideration of other options for outpatient dialysis were clear in the proposed rule. We received numerous comments discussing the four options we identified in the proposed rule (85 FR 9099), as well as the proposal to include outpatient dialysis as a facility type with maximum time and distance standards. The comments, as we have previously discussed, weighed these options and clearly discussed the benefits and drawbacks on the merits of the issues presented, indicating to us that our consideration of other options for outpatient dialysis was understood by commenters. We thank commenters for all of their input in helping to inform us as we considered a final policy concerning outpatient dialysis.

In this final rule, we are removing outpatient dialysis as a facility specialty type at § 422.116(b)(2) that is subject to network adequacy standards. Under our authority in § 422.116(a)(1), we intend to require that MA organizations submit an attestation that it has as an adequate network that provides the required access and availability to dialysis services, including outpatient facilities. We are finalizing the 27 provider specialty types and the other 13 facility types (that is, the types other than outpatient dialysis facilities) in § 422.116(b) as proposed.

Comment: A few comments questioned our proposal at § 422.116(b)(3) specifying that CMS may remove a provider or facility type from the network adequacy evaluation for a particular year by not including the type in the annual publication of the HSD reference file. A few commenters recommended that both additions and removals of provider and facility types be subject to notice and comment rulemaking.

Response: The HSD reference file is built annually by applying the rules in § 422.116. We reiterate the importance of the beneficiary protection at § 422.112(a), that even if a provider or facility specialty type is not subject to network adequacy standards, that access to providers at in-network cost-sharing must be provided by the MA organization. We proposed the ability to remove specialty types in the HSD reference file to account for circumstances where it may not be necessary to evaluate the number and accessibility of each of the 27 specialty and 13 facility types in a particular year. Additionally, as we described in our proposal, § 422.116(a) will permit us to require an MA plan to complete an attestation that it has an adequate network that provides the required access to and availability of provider or facility specialty types even where we do not evaluate access ourselves. Since network adequacy criteria are measured for each individual specialty type and do not roll up into an aggregate score, the removal of a specialty type from the network review will not affect the outcome of an MA plan's network review and, as discussed throughout this section of this final rule, we believe that there are adequate protections available to ensure that enrollee access to services is not compromised. We are finalizing § 422.116(b)(3) to allow CMS to remove a provider or facility type from the network adequacy evaluation for a particular year by not including the type in the annual publication of the HSD reference file.

Comment: Most commenters supported the proposed base time and distance standards. There were a few commenters that suggested that CMS consider alternative approaches to codifying a uniformly applied time and distance standard. A commenter suggested that CMS allow for the use of a combination of qualitative and quantitative standards. Others commenters suggested measures of provider availability (for example, percentage accepting new patients, timeliness of appointment availability), performance on access-related quality and patient experience measures, and degree of physical co-location of services.

Response: We appreciate the recommendations and, because we are always looking for new ways of improving the network adequacy reviews, will take them into consideration for potential future policy development. Our network adequacy methodology, as proposed and as finalized here, aims to objectively evaluate the networks of various types of coordinated care plans across a national landscape that includes urban, suburban, and rural regions. We believe that using quantitative methods that account for some degree of variance across these different regions provides a fair and reasonable evaluation that we can efficiently test against hundreds of MA plans annually. Therefore, we are finalizing base time and distance standards that vary by county type designation and take into account the nature of the provider or facility supply in the health care marketplace. Further, the customization process, which we are finalizing as proposed at paragraph § 422.116(d)(3), allows us to adjust the base time and distance standards, when needed, to take into account the unique characteristics of specific regions, such as geographic landscape, which may alter the pattern of care in a county. We also proposed an exceptions process at § 422.116(f), which allows us to also consider qualitative characteristics that may serve as the rationale for a valid exception when an MA network fails to meet time and distance standards. We have continued to hone and improve our network adequacy methodology since 2011 and believe our objective and transparent approach allows for the proper balance of quantitative and qualitative measures that allows CMS to quickly and efficiently measure the adequacy of hundreds of MA networks in a given year. We also note that some of the performance measures (for example, patient experience and access-related quality measures) suggested are

already included in CMS's MA plan Star Ratings system, which is used to measure how well plans perform in several categories, including quality of care and customer service. We do not believe it is necessary to duplicate those as part of network evaluations.

Therefore, we are finalizing the general rules for network adequacy proposed at § 422.116(a), with the exception of § 422.116(a)(3)(ii), which will not be finalized to align with how we are not finalizing specific standards for Outpatient Dialysis facilities. Also, we are finalizing the county type designations at § 422.116(c) and the maximum time and distance standards at § 422.116(d) as proposed, with the exception of the maximum time and distance standards for the Outpatient Dialysis facility type for reasons previously discussed.

Comment: A number of commenters supported the proposed base time and distance standards at § 422.116(d). A few commenters recommended changes to the proposed base time and distance standards in specific county type designations or due to the plan type. Some commenters recommended that Institutional Special Needs Plans (I–SNPs) should have reduced network adequacy standards for specific provider or facility types like podiatry, primary care, diagnostic radiology, physical therapy, occupational therapy, and speech therapy, or should be excepted altogether from the measures. Others recommended that we reduce time and distance standards for occupational therapy and dermatology in all county types, and for primary care and psychiatry in non-metro county types.

Response: We conduct network adequacy reviews at the contract level, meaning we evaluate the adequacy of the MA organization's network across all of their plan types (for example, HMOs, PPOs, SNPs); we do not singularly evaluate the network of a specific plan benefit package. We believe that conducting network reviews at the contract level allows us to consider the broadest availability of contracted providers and facilities for an MA organization while also providing administrative efficiency for CMS to evaluate fewer HSD network submissions. Therefore, our network methodology does not change base time and distance standards based on the plan type being reviewed, such as an I–SNP. We also do not believe that it would be necessary to change our network adequacy standards based on the plan types that we review. For example, while I–SNPs may be unique in that beneficiaries may receive a number of health care services from a single institution, there are also I–SNP institutionalized-equivalent beneficiaries that reside at home. Further, these beneficiaries may still need to travel to another facility to receive specialized care or the specialty providers will need to travel to deliver the care. As a result, we believe that even for plans like I–SNPs, it is important that MA organizations maintain a contracted network that can deliver medically necessary care and is compliant with our network adequacy standards.

We have honed and improved its base time and distance standards for each specific provider and facility type in each county designation over a period of nine years. For example, we updated maximum time and distance standards when the new county designation methodology was implemented (that is, moving from classifying counties based on metropolitan statistical areas to the current county designations) and have adjusted some standards based on a significant change in supply. We proposed base time and distance standards that we believe represent a fair expectation for health care patterns of delivery in the five county types based on many years of data and network evaluation. Additionally, the customization process, as proposed and finalized, allows us to adjust standards at the county and provider/facility type level where needed to take into account factors like utilization or supply patterns that indicate the base time and distance standards are not reflective of prevailing patterns of community health care delivery. Therefore, we are not making any changes to our base time and distance standards in the final rule and are finalizing these standards as proposed.

Comment: A number of commenters supported the minimum provider number requirements at § 422.116(e). Commenters supported CMS's policy that there be at least one contracted provider or facility specialty type within required time and distance standards that is accessible to Medicare beneficiaries. A commenter recommended that CMS use the same minimum provider ratio in the calculation of the minimum provider number requirement in all county types.

Response: We thank commenters for their support of this policy. As we described in our proposed rule, CMS established minimum ratios in 2011 using a number of data sources, including, Medicare fee-for-service claims data, American Medical Association (AMA) and American Osteopathic Association (AOA) physician workforce data, U.S. Census population data, National Ambulatory Medical Care Survey data, AMA data on physician productivity, and published literature. We proposed Minimum Ratios for each provider and county type at § 422.116(e)(3)(i). The Minimum Ratio is the number of providers required per 1,000 beneficiaries. As the overall population and population density widely varies between large metro and rural county types, so does the rate of health care utilization in these areas. Health care utilization patterns are higher in metro areas, and therefore, our proposed Minimum Ratios are slightly higher in metro county types. In accordance with our current rules at § 422.112(a)(10), we considered the prevailing patterns of community health care delivery, such as whether the service area is comprised of rural or urban areas, when developing the Minimum Ratios. We are finalizing the minimum number requirements as proposed in § 422.116(e).

Comment: Many commenters supported our proposed customization process at § 422.116(d)(3). In particular, commenters supported that CMS may only use customization to increase time and distance standards from the base standards. A commenter suggested that CMS allow health plans to provide feedback on county time and distance standard changes to ensure appropriate customization is consistent year after year. Other commenters suggested that geographic barriers like rivers, mountains, and oceans should trigger customization, in addition to supply shortages.

Response: We appreciate commenters' support of our customization process. We agree with commenters that geographic barriers that play a significant role in utilization patterns are triggering events that may result in the customization of time and distance standards by CMS. We clarify here, and in additional regulation text being finalized at § 422.116(d)(3), that when necessary due to utilization or supply patterns, CMS may set maximum time and distance standards for specific provider or facility types for specific counties by customization. We stated in the proposed rule that customization of base criteria may be triggered based on provider or facility supply shortages, information received through exception requests from plans, or from other sources, such as restrictions or limitations caused by state certificate of need (CON) laws. When information from these sources shows that utilization or supply patterns indicate the base time and distance standards are not reflective of prevailing patterns of community health care delivery, CMS

may customize the maximum time and distance standards. In the past, CMS has only customized maximum time and distance standards by increasing them above the base time and distance standard and will continue this policy by finalizing § 422.116(d)(iv). We solicited comment in the proposed rule about other sources of information that we should consider as part of the customization analysis, but we do not believe that it is necessary or appropriate to limit the source or type of information that could be used to trigger the customization analysis. By codifying a standard to guide when we will use customization without limiting the information that would indicate that utilization or supply standards make it necessary to use customized, instead of the base, time and distance standards, we are ensuring that the network adequacy evaluations appropriately reflect access and availability of health care for each area.

Customization of base time and distance standards occurs narrowly and is very specific to the provider or facility specialty type and county where the triggering event occurs. Further, MA organizations will not be subject to reductions in the time and distance standard below the base standards at § 422.116(d)(2); CMS will only be increasing from the base standards through customization to take into account the information and utilization and supply standards that trigger the need for customization and make it easier for MA organizations to comply with network adequacy standards. As such and because the regulation describes the standards governing the customization process, we do not believe an opportunity for prior review and comment on customized time and distance standards before implementation is the best course of action. As we mentioned, we consider information from exception requests to help inform our customization of time and distance standards. Should an MA organization continue to fail to meet customized time and distance standards, the organization may submit an exception request and provide further information about why its network cannot meet the standard. CMS will take that information under consideration for the current network review and may make additional adjustments to the customized time and distance standards in the following year. We believe this is the most efficient means of receiving MA organization input on customized standards as circumstances in counties change year over year. Therefore, we are finalizing the customization process at § 422.116(d)(3), with an addition to clarify that CMS may set maximum time and distance standards for provider or facility types for specific counties when necessary due to utilization or supply patterns.

Comment: We received numerous comments expressing support for the reduction in the percentage of beneficiaries residing within maximum time and distance standards in Micro, Rural, and CEAC counties from 90 percent to 85 percent. Some commenters described this as a reasonable adjustment in light of the limited availability of some providers in rural areas. They explained that this proposal could increase access to MA plans for beneficiaries residing in rural areas by bringing competition and better health care choices to beneficiaries. Other commenters that were supportive of the proposal also requested that CMS make this reduction applicable to all five county type designations, rather than limiting it to Micro, Rural, and CEAC counties. A few commenters suggested that we further reduce the percentage down to 80 percent.

We also received some comments that expressed opposition to this reduction. Some commenters expressed concern that reducing the threshold requirement may result in the unintended consequence of leaving some rural communities without appropriate access to essential services because it would reduce the incentives for MA plans to contract with specialists.

Response: We thank commenters for their viewpoints on our proposal to reduce the percentage of beneficiaries residing within maximum time and distance to 85 percent at § 422.116(d)(4)(i). We agree that a reduction is necessary in rural counties (Micro, Rural, and CEAC) due to the limited availability of providers and the lower population density in those areas. CMS considers the number and geographical distribution of eligible providers available to potentially contract with an MA organization when evaluating a network based on community patterns of care under § 422.112. The beneficiary population is typically less dense per square mile than in metro counties so we believe having a reduced threshold will make the standards more consistent with the community patterns of care in rural areas. As a result, we agree with commenters that this adjustment may increase access to MA plans for beneficiaries residing in rural areas. We do not believe that this reduction will result in leaving some rural communities without appropriate access to essential services. Our minimum number requirements proposed at § 422.116(e) require that an MA plan contract with at least one provider within maximum time and distance standards of a beneficiary in the area. Further, CMS rules at § 422.112(a) require that MA organizations must ensure that all covered services are available and accessible under the plan, regardless of how many providers or facilities are contracted with the MA organization. MA organizations must make arrangements for care outside the plan provider network, at in-network cost-sharing, when network providers are unavailable or the network is insufficient. Therefore, beneficiaries in these rural communities will continue to have access to specialty providers and facilities because MA organizations are still required to contract with at least one or must pay for health care services rendered at non-contracted Medicare participating providers at the Medicare FFS rate.

We proposed a modest reduction of 5 percent and limited this reduction to only Micro, Rural, and CEAC counties. We believe this to be an appropriate adjustment based on our data that shows that existing failures in MA plans' meeting the time and distance standards frequently occur at the range between 80 to 89 percent of beneficiaries. We understand that some commenters would like CMS to see an increased reduction or expand this reduction to all county types, however, we believe that the approach we are finalizing will allow us to observe the impacts of this policy change on MA plans and health care providers; we may consider further adjustments to the percentage as needed. Additionally, as this policy change was also intended to drive more MA plan access in rural areas, we do not believe it is necessary or appropriate at this time to apply this reduction to the access standard for metro counties. We are finalizing the reduction in the percentage of beneficiaries residing within maximum time and distance to 85 percent for Micro, Rural, and CEAC counties at § 422.116(d)(4)(i).

Comment: We received numerous comments about the 10-percentage point telehealth credit towards the percentage of beneficiaries residing within published time and distance standards for applicable provider specialty types proposed at § 422.116(d)(5). Most commenters were very supportive and appreciated CMS' support of telehealth goals and thought that CMS's proposal would incentivize MA organizations to contract with providers that have adopted telehealth technology. A few

commenters were opposed to this ''telehealth credit'' and felt that telehealth should be implemented into network adequacy in a way that does not diminish access to in-person care. These commenters believed that allowing a telehealth credit would make it too easy for MA organizations to comply with a standard that is set for in-person access to a provider. Also, opposing commenters believed that this policy may unintentionally encourage plans to use telehealth services as substitutes for existing in-person services, even in areas where provider availability and beneficiary access are strong.

Response: We appreciate commenters support for this proposal as well as the concerns that were raised by the commenters that opposed it. We believe the telehealth credit that we proposed upholds maximum time and distance standards for the applicable provider specialty types and provides a modest incentive for MA organizations to supplement their networks with providers that can furnish additional telehealth benefits. Our proposal does not decrease the maximum time and distance standards that must be maintained for compliance with our network adequacy measures for the applicable provider types; it allows for a reduced portion of the beneficiary population to be within those maximum time and distance standards. For example, in Metro counties, MA organizations would still need to ensure that they contract with in-person providers that are within maximum time and distance standards of at least 80 percent of the beneficiary population even after the credit is applied. We believe it is important and appropriate to account for contracted telehealth providers in evaluating network adequacy consistent with reflecting how MA plans supplement, but do not replace, in-person networks with telehealth providers. The rules at § 422.135(c) for providing additional telehealth benefits require that the MA organizations furnish in-person access to the specified Part B service at the election of the enrollee. This protection preserves the beneficiary's right to choose when they would prefer to have medically necessary care provided in-person rather than through electronic exchange (that is, through electronic information and telecommunications technology). Further, our telehealth credit proposal does not count telehealth-only providers as equal to providers that deliver in-person care. We limited the impact that supplementing a network with telehealth providers could have on the network adequacy standards by offering a 10-percentage point credit, while maintaining the maximum time and distance standards required for the applicable provider types. We believe this approach appropriately incentivizes MA organizations to contract with providers that offer additional telehealth benefits and maintains standards that ensure that in-person providers are within a reasonable time and distance for most beneficiaries.

Comment: Some commenters suggested that CMS modify the telehealth credit by increasing the credit to as high as a 20-percentage point credit.

Response: Our proposal attempted to strike the proper balance between incentivizing MA organizations to contract with providers that offer additional telehealth benefits while also maintaining adequate access to in-person care for the same provider specialties. Therefore, we proposed a 10-percentage point credit towards the percentage of beneficiaries residing within maximum time and distance standards. We believe a 10-percentage point credit is an appropriate amount that proportionately supplements a plan's percentage threshold because telehealth providers add value to a contracted provider network, but should not have the same level of significance or value as an in-person provider. Additionally, information from prior network adequacy reviews show that many failures in meeting time and distance standards occur in this 80 to 89 percent range. We believe an increase to a 20-percentage point credit would be too significant at this time. We plan to observe the frequency and impact of this telehealth credit in network adequacy reviews and will consider adjusting this percentage in the future as needed.

Comment: A few commenters recommended that CMS add to the applicable provider list of dermatology, psychiatry, cardiology, neurology, and otolaryngology proposed at § 422.116(d)(5) by also including the provider types of ophthalmology, allergy and immunology, nephrology, primary care, gynecology, endocrinology, infectious diseases, or making all provider types applicable for the telehealth credit. Commenters encouraged CMS to expand the list of specialty providers to account for advances in medical technology and promote beneficiary choice in how to receive medical services.

Response: We appreciate commenters' suggestions on expanding the list of applicable provider types for this telehealth credit. As we explained in the previous comment response, we believe the telehealth credit amount is properly balanced to maintain adequate access to in-person care while also incentivizing MA organizations to contract with telehealth providers. We note that in the proposed rule, we did not believe it was necessary to take telehealth into account for primary care providers. 85 FR 9099. However, the use of and access to primary care doctors via telehealth, as well as other provider specialties highlighted by commenters (whose comments referred to circumstances outside the Public Health Emergency), has been critically important in delivering medical care to Medicare beneficiaries during the during the COVID–19 pandemic Public Health Emergency. Based on our experience during this emergency, we observed how important it is to have policies that encourage the widespread availability of telehealth services at all times. Additionally, President Trump's Executive Order 13890 on Protecting and Improving Medicare for Our Nation's Seniors (October 3, 2019) called for enhanced access to health outcomes made possible through telehealth services or other innovative technologies as a way to secure and improve Medicare. In light of the COVID–19 pandemic and this Executive Order, we now believe that we should expand the list of specialty provider types finalized at § 422.116(d)(5) and there is no reason to restrict this credit to only provider types that are the most apt to provide telehealth services or for which we have seen potential for failing to meet the specific time and distance standards. New medical technologies and treatments are rapidly evolving across various providers and we would like to broaden the scope of eligible providers to account for these developments by implementing recommendations from commenters on the provider types in § 422.116(b)(1) that should be eligible for the telehealth credit. However, we also do not believe that it is appropriate to make this credit available to all provider types at this time. Therefore, based on the comments received, we are adding the following provider types to the list finalized at § 422.116(d)(5): Ophthalmology, Allergy and Immunology, Nephrology, Primary Care, Gynecology/OB/GYN, Endocrinology, and Infectious Diseases.

Comment: A few commenters recommended that we modify CMS's proposal at § 422.116(d)(5) to include 1876 cost plan telehealth providers that provide telehealth services through supplemental benefits.

Response: Our proposal at § 422.116(d)(5) limited the credit to

providers that provide additional telehealth benefits, as defined in § 422.135, in its contracted networks. As we pointed out in the proposed rule, additional telehealth benefits described at § 422.135 only apply to MA plans. For that reason, our proposal did not extend the 10-percentage point credit to cost plans. We believe this is appropriate because of the protections and rules that exist for additional telehealth benefits that that require access to in-person care at the election of the enrollee. Telehealth services offered through supplemental benefits are not subject to these rules and may be too limited in scope to warrant a credit for network adequacy. Therefore, we are finalizing this telehealth credit as proposed at § 422.116(d)(5).

Comment: We received numerous comments in support of our proposal at § 422.116(d)(6) that MA organizations may receive a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards for affected provider and facility types in states that have CON laws, or other state imposed anticompetitive restrictions, that limit the number of providers or facilities in a county or state. Some commenters expressed agreement with our discussion in the proposed rule that CON laws have a negative impact on network adequacy, reduce competition, result in higher prices and lower patient access. Other commenters opposed the ''CON law credit'' and disagreed with our viewpoint on the impact that CON laws. Opposing commenters suggested that CON laws are not a significant barrier to providers in underserved areas and help assure that there is not an overabundance of specialized facilities that need to treat patients in order to remain in business, which causes an overutilization of services. These commenters were concerned that a 10-percentage point credit may hinder enrollee access to providers. We received some comments seeking clarification on the term ''other anticompetitive restrictions'' and the conditions under which the CON law credit will be available.

Response: We appreciate commenters' varying viewpoints on CON laws and their impact on network adequacy. We continue to believe that CON laws adversely affect competition and free market entry, and therefore, MA organizations must pay more for benefits when there is a limited supply of providers or facilities. We believe the 10-percentage point credit is an appropriate adjustment to make for MA organizations that contract with providers or facilities that are affected by CON laws in counties and states. As previously mentioned, prior network adequacy reviews show that many failures in meeting time and distance standards occur in the 80 to 89 percent range. Like the telehealth credit, this credit does not reduce the maximum time and distance criteria required for specific providers or facilities; it reduces the compliance threshold that MA organizations must meet in order to meet our network adequacy standards. Even when this credit applies, MA organizations must still contract providers and facilities where a majority of beneficiaries reside within maximum time and distance standards.

We proposed that MA organizations may receive a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards for affected provider and facility types in states that have CON laws, or *other state imposed anticompetitive restrictions,* that limit the number of providers or facilities in a county or state. We are implementing this network adequacy policy in furtherance of President Trump's Executive Order 13890 on Protecting and Improving Medicare for Our Nation's Seniors (October 3, 2019), which called for adjustments to network adequacy requirements to account for the competitiveness of state health care markets, including taking into account whether states maintain Certificate of Need (CON) laws or *other anticompetitive restrictions.* We clarify here that the term ''anticompetitive restrictions'' at § 422.116(d)(6) is meant to encompass state laws that restrict the provider or facility supply of specialty types listed at § 422.116(b), even if the state does not formally call them CON laws. For example, Wisconsin does not have a CON law, but has a limit on the maximum number of approved hospital beds .[52]

Additionally, we clarify that CMS will identify the states, counties and provider/facility specialty types where the CON law credit will be available for MA organizations. CMS has conducted comprehensive research on every state to determine whether the state uses CON laws or other anticompetitive restrictions and whether those laws affect the provider or facility types in our network adequacy standards at § 422.116(b). As we have described in regulation text, CMS may customize base time and distance standards in states with CON laws in lieu of allowing for the 10-percentage point credit. We clarify here and in regulation text at § 422.116(d)(6), that CMS may use customization when necessary due to utilization or supply patterns. Therefore, the 10-percentage point credit will not be allowable in counties where the specific provider or facility type maximum time and distance standards have already been customized. CMS will use the HPMS Network Management Module to identify the county and provider/facility combinations that are eligible for this 10-percentage point credit and MA organizations will need to submit a credit request for each provider or facility type they believe has been affected by the CON or anticompetitive laws.

Therefore, we are finalizing at § 422.116(d)(6) that in a state with CON laws, or other state imposed anti-competitive restrictions that limit the number of providers or facilities in the state or a county in the state, CMS will either award the MA organization a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards for affected providers and facilities in paragraph (b) of this section or, when necessary due to utilization or supply patterns, customize the base time and distance standards.

Comment: We received some comments about the cumulative effect of the telehealth and CON law credits on the percentage of beneficiaries residing within published time and distance standards. Some commenters questioned whether it was allowable to combine the two credits and others expressed concern with the effect of combining the two credits. Commenters were concerned that the combined change in the compliance percentage would likely have adverse impacts on provider access and choice.

Response: When discussing the CON law credit in the proposed rule, we stated that the CON law credit could be ''in addition to'' the telehealth credit, when applicable. We confirm that interpretation here and reiterate that both of these credits may be applied together to the percentage of beneficiaries residing within maximum time and distance standards at § 422.116(d)(4). We note that these credits do not reduce the actual maximum time and distance standards themselves, and that CMS still requires that MA organizations contract with providers where a majority of beneficiaries (that is, no less than 65 percent in rural counties, and 70 percent in non-rural counties, when both credits apply) reside within maximum time and distance standards for in-person access to care when

[52] *http://docs.legis.wisconsin.gov/statutes/statutes/150/VII/93.*

needed. Additionally, we reiterate that § 422.112(a) requires that MA organizations must ensure that all covered services are available and accessible under the plan and that MA organizations must maintain a network of providers to provide adequate access to covered services and must make arrangements for care outside the plan provider network, at in-network cost-sharing, when network providers are unavailable or the network is inadequate.

Comment: A few commenters recommended changes to our proposed exceptions process. Some commenters recommended that CMS shift from categorically treating an ''inability to contract'' as an invalid rationale for an exception and instead consider it a valid rationale relating to consolidated or concentrated provider markets. Others recommended that CMS consider exceptions based on documented provider activities that have resulted in anticompetitive practices impeding efforts to meet network adequacy standards. Another commenter suggested that where there may be repeated exception requests based on geographical barriers, CMS should consider granting permanent exceptions. Finally, a commenter requested that CMS revise its language in § 422.116(f) to expressly provide for exceptions for I–SNPs because they commonly furnish services in long-term care facilities.

Response: Under our proposal, an MA organization may request an exception when two criteria are met. First, certain providers or facilities are not available for the MA organization to meet the network adequacy criteria as shown in the Provider Supply file for the year for a given county and specialty type; second, the MA organization has contracted with other providers and facilities that may be located beyond the limits in the time and distance criteria but are currently available and accessible to most enrollees, consistent with the local pattern of care. We explained in the proposed rule the meaning of ''available'' by providing examples, such as when the provider has moved or retired, or when the provider/facility does not contract with any organizations or exclusively with another organization. (85 FR 9102–9103). However, we distinguish these examples from situations where an MA organization is unable to successfully negotiate and establish a contract with a provider or facility, which we refer to as the ''inability to contract.'' The non-interference provision at section 1854(a)(6) of the Act prohibits us from requiring any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services or require a particular price structure for payment under such a contract. As such, we cannot assume the role of arbitrating or judging the bona fides of contract negotiations between an MA organization and available providers or facilities. With respect to comments about ''documented provider activities that have resulted in anticompetitive practices,'' we believe that commenters are also referring to price negotiations between MA organizations and providers. We maintain that the ''inability to contract'' with an available provider or facility is not a valid justification for an exception at § 422.116(f). Therefore, we will generally not accept an organization's assertion that it cannot meet our network adequacy criteria because providers/facilities are not willing to contract with it.

With respect to comments about permanent exceptions for geographic barriers, we clarify here that we would not create a ''permanent'' exception, as this would unnecessarily burden the exception process. Instead, we would utilize our customization process to recalibrate maximum time and distance requirements in accordance with the local pattern of care. As mentioned in our discussion about customization, we use information received through exception requests to stay informed and determine which counties or provider/facility types require a permanent adjustment in maximum time and distance standards through customization to account for things such as geographic characteristics or changes in supply.

Finally, we reiterate here that we do not believe it is necessary to change network adequacy standards based on the plan types that we review. Beneficiaries may still need to travel to another facility to receive specialized care or the specialty providers may need to travel to deliver the care to the long-term care facility. As a result, we do not believe any specific exceptions are needed for I–SNPs.

We proposed to codify the three criteria that we consider when evaluating exception requests at paragraphs (f)(2)(i), (ii) and (iii); that CMS considers whether the current access to providers and facilities is different from the HSD reference and Provider Supply files for the year; there are other factors present, in accordance with § 422.112(a)(10)(v), that demonstrate that network access is consistent with or better than the original Medicare pattern of care; and approval of the exception is in the best interests of beneficiaries. We reiterate that all three criteria must be met for CMS to approve an exception. We are finalizing the exceptions process and these criteria at § 422.116(f) as proposed.

Comment: Some commenters, in connection with a proposal to revise § 422.502 to address how CMS would use an entity's past performance on an MA contract in evaluating applications for new plans or service area expansions, stated that CMS should be more specific about what is and is not a basis for denying applications in connection with network adequacy in order to minimize uncertainty and unpredictability for MA organizations. Commenters suggested that CMS should add other and more specific criteria for use in considering applications.

Response: Although we are not addressing in this final rule the proposal to revise § 422.502 to address our use of information about past performance in evaluating an application, we understand that our statement in the proposed rule about how we would require an entity applying for a new MA contract to provide an attestation about the adequacy of its network could be seen as touching on that topic. We will address our proposal about § 422.502 in a future final rule, but believe that additional clarity regarding attestations about meeting the network adequacy regulation and how they would be used in the context of applications for new MA contracts or service area expansions should be addressed as part of our network evaluation regulation.

We proposed specific regulation text (which we are finalizing) in § 422.116(a) that each network-based MA plan must demonstrate that it has an adequate contracted provider network. In addition, we proposed that when required by CMS, an MA organization must attest that it has an adequate network for access and availability of a specific provider or facility type that CMS does not independently evaluate in a given year (85 FR 9093). We explained that we anticipated requiring such attestation in the MA organization's application or contract for a given year but we might require the attestation when performing other network adequacy reviews, such as when there is a significant change in the MA plan's provider network.

Under our current network adequacy policy, as described in the PRA approved collection of information titled, ''Triennial Network Adequacy Review for Medicare Advantage Organizations and 1876 Cost Plans'' (CMS–10636) and referenced in our

proposed rule, we removed network reviews from the application process beginning in 2018 for contract year 2019. Therefore, failures detected during network reviews are no longer used as a basis to deny an MA application. In the proposed rule, we made clear that an attestation could be used in connection with applications. In light of the comments discussed above, and to address the intersection of our regulations regarding network adequacy and the bases for denying applications, we are finalizing regulatory text to explicitly provide that we do not require information other than an attestation regarding compliance with network adequacy requirements as part of the application for a new or expanding service area and will not deny such an application on the basis of such requirements. This provides greater clarity regarding how network adequacy and the application process intersect by codifying the current practice of relying on other mechanisms, such as our triennial reviews, to evaluate compliance with the specific network adequacy standards finalized in § 422.116 and to enforce those standards. The provision we are finalizing here at § 422.116(a)(1)(ii), however, does not prohibit CMS from considering or using information about an entity's failure to comply with a MA contract for purposes of an application denial when or if that compliance failure was associated with access to services or network adequacy evaluations and resulted in the imposition of an intermediate sanction or civil money penalty under to part 422 subpart O, with the exception of a sanction imposed under § 422.752(d). Therefore, we are finalizing regulatory text at § 422.116(a)(1)(ii) that CMS does not require information, other than an attestation, regarding compliance with § 422.116 as part of an application for a new or expanding service area and will not deny application on the basis of an evaluation of the applicant's network for the new or expanding service area.

After careful consideration of all comments received, and for the reasons set forth in the proposed rule and in our responses to the related comments summarized earlier, we are finalizing the proposed changes to §§ 417.416(e)(3) and 422.116 with the following modifications:

- We are finalizing regulatory text at § 422.116(a)(1)(ii) that CMS does not require information, other than an attestation, regarding compliance with § 422.116 as part of an application for a new or expanding service area and will not deny application on the basis of an evaluation of the applicant's network for the new or expanding service area. Accordingly, we are designating the text we proposed at paragraph (a)(1) as paragraph (a)(1)(i) in the final regulation.
- We are not finalizing § 422.116(a)(3)(ii), which clarified the definition of the facility type Outpatient Dialysis.
- We are not finalizing Outpatient Dialysis in the list of facility specialty types at § 422.116(b)(2) and are finalizing the list of other facility-types as proposed but with different numbering, accordingly.
- We are not finalizing the base maximum time and distance standards for Outpatient Dialysis for all county designations at § 422.116(d)(2).
- We are finalizing the customization process at § 422.116(d)(3) with a modification that describes what triggers customization by CMS.
- We are finalizing § 422.116(d)(5) as proposed with the addition of Ophthalmology, Allergy and Immunology, Nephrology, Primary Care, Gynecology/OB/GYN, Endocrinology, and Infectious Diseases provider specialty types to the list of provider types for which the telehealth credit is available.
- We are finalizing § 422.116(d)(6) with a modification that describes when CMS may use the customization process as it relates to Certificate of Need or other anticompetitive laws.

M. Special Election Periods (SEPs) for Exceptional Conditions (§§ 422.62, 422.68, 423.38, and 423.40)

1. Part C Special Election Periods (§ 422.62)

Section 1851(e)(4) of the Act establishes special election periods (SEPs) during which, if certain circumstances exist, an individual may request enrollment in a Medicare Advantage (MA) plan or discontinue the election of an MA plan and change his or her election to original Medicare or to a different MA plan. We have codified SEPs for the following circumstances specifically addressed in section 1851(e)(4) of the Act:

- SEP for Non-renewals or Termination.
- SEP for Changes in Residence.
- SEP for Contract Violation.

Section 1851(e)(4)(D) of the Act also grants the Secretary the authority to create SEPs for individuals who meet other exceptional conditions. This authority is codified at § 422.62(b)(4). CMS has historically included in regulation those SEPs that the statute explicitly authorizes and has established the SEPs for exceptional circumstances in our subregulatory guidance rather than through regulation.

We proposed to codify a number of SEPs that we have adopted and implemented through subregulatory guidance as exceptional circumstances SEPs. Consistent with § 422.68(c), we also proposed to revise § 422.68(d) to clarify that for SEPs that are described in § 422.62(b), elections are effective as of the first day of the first calendar month following the month in which the election is made, unless otherwise noted.

The proposed MA SEPs are summarized below. (Readers should refer to the proposed rule for more detail on these SEPs.):

SEP for Employer/Union Group Health Plan (EGHP) Elections. We proposed to revise § 422.62(b)(4) to codify a SEP for individuals making MA enrollment requests into or out of employer sponsored MA plans, for individuals to disenroll from an MA plan to take employer sponsored coverage of any kind, and for individuals disenrolling from employer sponsored coverage (including COBRA coverage) to elect an MA plan.

SEP for Individuals Who Disenroll in Connection with a CMS Sanction. At new § 422.62(b)(5), we proposed to codify the SEP for individuals enrolled in an MA plan offered by an MA organization that is sanctioned by CMS.

SEP for Individuals Enrolled in Cost Plans that are Non-renewing their Contracts. At new § 422.62(b)(6), we proposed to codify the SEP for individuals enrolled in cost plans that are non-renewing their contracts for the area in which the enrollee lives.

SEP for Individuals in the Program of All-inclusive Care for the Elderly (PACE). At new § 422.62(b)(7), we proposed to codify the SEP allowing an MA plan enrollee to disenroll from an MA plan at any time in order to enroll in PACE.

SEP for Individuals Who Terminated a Medigap Policy When They Enrolled For the First Time in an MA Plan and Who Are Still in a Trial Period. We proposed, at new § 422.62(b)(8), to codify the SEP for individuals who are eligible for guaranteed issue of a Medigap policy under section 1882(s)(3)(B)(v) of the Act upon disenrollment from the MA plan in which they are enrolled.

SEP for Individuals With ESRD Whose Medicare Entitlement Determination Was Made Retroactively. We proposed to codify at new § 422.62(b)(9) that individuals whose Medicare entitlement determination based on ESRD was made retroactively would have a SEP to prospectively elect an MA plan offered

by the MA organization, provided they met certain requirements.

SEP for Individuals Whose Medicare Entitlement Determination Was Made Retroactively. We proposed, at new § 422.62(b)(10), to codify a SEP for individuals whose Medicare entitlement determination was made retroactively.

SEP for Individuals Who Lose Special Needs Status. At new § 422.62(b)(11), we proposed to codify the SEP for individuals enrolled in an MA special needs plan (SNP) who are no longer eligible for the SNP because they no longer meet the applicable special needs status.

SEP for Individuals Who Belong to a Qualified SPAP or Who Lose SPAP Eligibility. At new § 422.62(b)(12), we proposed to codify a SEP for individuals who belong to a qualified State Pharmaceutical Assistance Program (SPAP) to make one election to enroll in an MA–PD plan each calendar year.

SEP for Enrollment Into a Chronic Care SNP and for Individuals Found Ineligible for a Chronic Care SNP. At new § 422.62(b)(13), we proposed to codify the SEP allowing individuals with severe or disabling chronic conditions to enroll in a Chronic Care SNP (C–SNP) designed to serve individuals with those conditions.

SEP for Disenrollment from Part D to Enroll in or Maintain Other Creditable Coverage. At new § 422.62(b)(14), we proposed to codify the SEP that provides an opportunity for individuals to disenroll from an MA–PD plan (only by electing Original Medicare or an MA-only plan) in order to enroll in or maintain other creditable drug coverage (such as TRICARE or VA coverage) as defined in § 423.56(b).

SEP to Enroll in an MA Plan with a Star Rating of 5 Stars. At new § 422.62(b)(15), we proposed to codify the SEP allowing an eligible individual to enroll in an MA plan with a Star Rating of 5 stars during the plan contract year in which that plan has the 5-star overall rating.

SEP for Non-U.S. Citizens who Become Lawfully Present. At new § 422.62(b)(16), we proposed to codify the SEP for non-U.S. citizens who become lawfully present in the United States.

SEP for Providing Individuals who Requested Materials in Accessible Formats Equal Time to Make Enrollment Decisions. We proposed to codify, at new § 422.62(b)(17), a SEP for situations where an MA organization or CMS was unable to provide required notices or information in an accessible format, as requested by an individual, within the same timeframe that it was able to provide the same information to individuals who did not request an accessible format.

SEP for Individuals Affected by a FEMA-Declared Weather-Related Emergency or Major Disaster. We proposed to codify, at new § 422.62(b)(18), the SEP for individuals affected by a weather-related emergency or major disaster who were unable to make an election during another valid election period.

SEP for Significant Change in Provider Network. At new § 422.62(b)(23), we proposed to codify the SEP that is available when CMS determines that mid-year changes to an MA plan's provider network are significant, based on the effect on, or potential to affect, current plan enrollees' continued access to covered benefits.

SEP for Individuals Enrolled in a Plan Placed in Receivership. We proposed to establish a new SEP, at new § 422.62(b)(24), for individuals enrolled in plans offered by MA organizations experiencing financial difficulties to such an extent that a state or territorial regulatory authority has placed the organization in receivership.

SEP for Individuals Enrolled in a Plan that has been Identified by CMS as a Consistent Poor Performer. We proposed to establish a new SEP, at new § 422.62(b)(25), for individuals who are enrolled in plans identified with the low performing icon (LPI) in accordance with § 422.166(h)(1)(ii).

SEP for Individuals Affected by a Federal Employee Error. At new § 422.62(b)(21), we proposed to codify a SEP for individuals whose enrollment or non-enrollment in an MA–PD plan is erroneous due to an action, inaction or error by a federal employee.

SEP for Other Exceptional Circumstances. Lastly, we proposed to retain the authority currently at § 422.62(b)(4) to create SEPs for individuals who meet other exceptional conditions established by CMS and move it to new § 422.62(b)(26).

Also based on the Secretary's authority to create SEPs for individuals who meet exceptional conditions, we proposed to codify the following SEPs currently outlined in subregulatory guidance that coordinate with Part D election periods:

SEP for Individuals Who Experience an Involuntary Loss of Creditable Prescription Drug Coverage. At new § 422.62(b)(19), we proposed to codify the SEP for individuals who experience an involuntary loss of creditable prescription drug coverage, including a reduction in the level of coverage so that it is no longer creditable but not including any such loss or reduction due to a failure to pay premiums.

SEP for Individuals Who Are Not Adequately Informed of a Loss of Creditable Prescription Drug Coverage. At new § 422.62(b)(20), we proposed to codify a SEP for individuals who are not adequately informed of a loss of creditable prescription drug coverage, or that they never had creditable coverage.

SEP for Individuals Eligible for an Additional Part D IEP. At new § 422.62(b)(22), we proposed to codify the SEP for an individual who is eligible for an additional Part D Initial Enrollment Period (IEP) to have an MA SEP to coordinate with the additional Part D IEP.

These proposed revisions would codify existing subregulatory guidance for SEPs that MA organizations have previously implemented and are currently following, except the SEP for Individuals Enrolled in a Plan Placed in Receivership and the SEP for Individuals Enrolled in a Plan that has been identified by CMS as a Consistent Poor Performer. We also proposed minor editorial changes in § 422.62(b) and (c), such as changing ''Original Medicare'' to ''original Medicare.''

In general, we received support for the proposed SEPs. We received specific comments on the following proposed SEPs. (Comments that apply to SEPs proposed for both MA and Part D will be addressed in this section and not repeated in the Part D SEP section.) The comments on those proposals and our responses follow:

SEP for Employer/Union Group Health Plan (EGHP) Elections

Comment: A commenter recommended that we revise the current description of this SEP, which is that it is available to individuals who have (or are enrolling in) an employer or union sponsored MA plan, and change it to indicate that it is available to individuals who have (or are enrolling in) an employer or union sponsored plan.

Response: We interpret this comment as a request to ensure that this SEP is available to individuals who have (or are enrolling in) an employer or union sponsored plan that is not an MA plan. As proposed, this SEP is available to individuals who are moving from employer or union coverage of any kind to an employer or union sponsored MA plan. In addition, the SEP is available to individuals who wish to disenroll from an MA plan to take employer or union sponsored coverage of any kind. As such, we believe the comment is addressed by the SEP, as proposed.

Comment: A commenter recommended that CMS codify the retroactive effective date guidelines related to this SEP, which are referenced in subregulatory guidance. Specifically, where there is a delay between the time in which the member completes the enrollment or disenrollment request with the EGHP and when it is ultimately received by the health plan, the current guidelines indicate that the effective date may be retroactive up to, but may not exceed, 90 days from the date the MA organization received the request from the employer or union group. The disenrollment effective date guidelines indicate up to 90 days' retroactive payment adjustment is possible in cases where the EGHP does not provide the plan with timely notification of a member's requested disenrollment.

Response: We did not propose to codify a provision for retroactive payment adjustment due to employer or union delays in providing the MA organization with timely notification of a member's requested disenrollment, and we decline to adopt such a provision at this time. It has been CMS' longstanding expectation that in the event an MA organization chooses to delegate to an employer or union the collection and initial processing of beneficiary enrollment and disenrollment requests, the MA organization's agreement with the employer or union would require the employer or union to meet enrollment and disenrollment processing timeliness requirements that ensure the timely submission of enrollment and disenrollment requests. As such, retroactivity is necessary when the employer or union fails to meet these processing timeliness requirements.

SEP for Individuals Who Terminated a Medigap Policy When They Enrolled For the First Time in an MA Plan and Who Are Still in a Trial Period

Comment: A commenter who expressed support for this proposal urged CMS to ensure that beneficiaries under age 65 with ESRD who have guaranteed issue rights under state laws and rules are aware of them.

Response: We appreciate the commenters' support and agree that education and outreach are essential for individuals to understand their enrollment options. We will continue to partner with existing stakeholders to ensure that clear and comprehensive information is provided to beneficiaries so they are able to make an informed coverage choice.

SEP for Individuals Affected by a Federal Employee Error

Comment: A commenter, citing some stakeholder concerns regarding the 2019 redesign of the Medicare Plan Finder (MPF) tool, requested that CMS articulate in regulatory language (either in the SEP for individuals affected by a federal employee error or a separate entry) that a SEP for exceptional circumstances may exist when there are errors in the MPF or other CMS-issued or managed information platforms that beneficiaries used when making their decisions.

Response: We appreciate the comment. As the MPF and other CMS-issued or managed information platforms are the responsibility of the federal government, a beneficiary who relied on erroneous information on these platforms would be eligible for this SEP. As a result, we do not see a need to revise the current regulatory text or establish a new, separate SEP.

SEP for Individuals Affected by a FEMA-Declared Weather-Related Emergency or Major Disaster

Comment: A number of commenters supported the proposal to codify this SEP and many of them recommended that it be expanded to address State-declared emergencies and public health emergencies such as COVID–19. A commenter questioned if the SEP would apply when FEMA provides fire management assistance. Commenters also requested that the end date should be revised so that the SEP is available to eligible individuals in cases where the emergency is declared with a retroactive effective date and/or lasts for more than 4 months.

Response: We appreciate the comments and agree that eligibility for this SEP should not be solely contingent upon a FEMA declaration. Based on these comments and consistent with our goal of providing an enrollment or disenrollment opportunity to an individual who missed an election period due to circumstances beyond his or her control, we will revise the proposed SEP to include any emergency declaration issued by a Federal, state, or local government entity in response to a disaster or other emergency. This would not include instances in which fire management assistance is provided by FEMA, as this occurs prior to the declaration of an emergency or major disaster as part of state and/or local government efforts to stop the spread of fire and mitigate fire risk to the built environment, and is not itself an emergency declaration. We also agree with the comment that the SEP end date should be revised so that the SEP is available to eligible individuals in cases where the emergency is declared with a retroactive effective date and/or lasts for more than four months. We believe that the SEP end date should be related to the end of the emergency period, not the start of the emergency period.

As such, in §§ 422.68(b)(18) and 423.38(c)(23) we will change the scope of the SEP so that it applies to FEMA-declared emergencies/disasters, as well as disaster or other emergency declarations issued by a federal, state or local government entity. It will be available in the geographic areas identified in the emergency/disaster declaration. We also specify in this paragraph that the SEP will—

- Start as of the date the declaration is made, the incident start date or, if different, the start date identified in the declaration, whichever is earlier; and
- End 2 full calendar months following the end date identified in the declaration or, if different, the date the end of the incident is announced, whichever is later. This 2-month period is consistent with other longstanding SEPs such as the SEP for Significant Change in Provider Network and the SEP for Individuals Whose Medicare Entitlement Determination Made Retroactively.

In finalizing the SEP with these revisions, we will retain the requirement that the individual was eligible for an election period at the time of the incident period and did not make an election during that election period because he or she was prevented from doing so due to the incident. We will refer to this SEP as the *SEP for Government Entity-Declared Disaster or Other Emergency*.

SEP for Individuals Enrolled in a Plan Placed in Receivership

Comment: A commenter stated that it is unclear how an MA organization might know if another MA organization is having financial problems during the enrollment period and, therefore, would not know if a beneficiary is eligible for this SEP.

Response: The SEP is available only to individuals enrolled in a plan offered by an organization that has actually been placed into receivership, which, in our experience, is always a well-publicized event in the impacted area, usually involving a high level of media attention. We believe that MA organizations offering plans in the area in which another MA organization has been placed into receivership will be aware of such an event through its normal course of business in the areas it serves. When a beneficiary requests

enrollment on the basis of their current plan being placed into receivership, the new plan can accept the beneficiary's verbal or written attestation as proof of their eligibility for this SEP.

Comment: Two commenters suggested that CMS allow MA plans and Part D sponsors to accept verbal beneficiary attestation as proof of eligibility for this SEP and not require additional proof of election eligibility. They believed that allowing verbal beneficiary attestation will expedite enrollment processing and may reduce enrollment denials. Additionally, they believed it would be consistent with current SEPs permitting verbal attestation for election period eligibility, such as the SEPs for Change in Residence, EGHP, etc.

Response: We did not propose that additional proof of eligibility for this SEP be required. Consistent with longstanding policy regarding eligibility for any SEP, an applicant's written or verbal attestation of SEP eligibility is sufficient.

SEP for Individuals Enrolled in a Plan That Has Been Identified by CMS as a Consistent Poor Performer

Comment: A commenter, who expressed support for this new SEP and the new SEP for Individuals Enrolled in a Plan Placed in Receivership, requested that if a beneficiary who is eligible for these new SEPs or any other SEP has an agent of record, that a pathway be created for the agent of record to make the plan change.

Response: Beneficiaries are not precluded from using an agent/broker or any other available means to enroll in a plan when the beneficiary qualifies for a SEP.

Comment: Another commenter who expressed support for this new SEP and the new SEP for Individuals Enrolled in a Plan Placed in Receivership stated that impacted beneficiaries should be able to make elections utilizing these new SEPs only through contacting CMS directly, adding that to include these two new SEPs on plan enrollment forms, enrollment websites and other enrollment mechanisms is an unnecessary burden. The commenter believed that adding two new SEPs would be confusing for beneficiaries, as there are already numerous SEPs for beneficiaries to understand. This commenter also stated that the two new SEPs should be available to beneficiaries only outside of the Annual Enrollment Period (AEP) and only until such time as CMS terminates its contract with the plan. The commenter stated that an MA parent organization would not be able to identify a plan that has been identified by CMS as a consistent poor performer or a plan that has been placed in receivership and requested that CMS not require plans to offer these two new SEPs until contract year 2022.

Response: We appreciate the comment and believe that any potential beneficiary confusion can be minimized by presenting these two new election opportunities to beneficiaries in a clear and accurate manner. We believe that it is important that the SEPs be available throughout the year, not just outside of the AEP, given the effective date implications. That is, if a beneficiary finds it necessary to change plans during October or November using one of these SEPs, their new coverage should be effective the next month and they should not have to wait until January 1 or later. We disagree with the commenter and do not believe that it is an unnecessary burden to mention these two SEPs in plan materials where other SEPs are listed, such as the Attestation of Eligibility for an Enrollment Period. Exclusion of the two new SEPs would result in beneficiaries not being fully aware of all potential election periods available to them. With regard to the comment that an MA parent organization would not be able to identify a plan that has been identified by CMS as a consistent poor performer, we note that since plans are able to accept a verbal or written attestation from the beneficiary that they are eligible for a SEP, plans are able to accept a verbal or written attestation regarding eligibility for the SEP for Individuals Enrolled in a Plan Placed in Receivership and the SEP for Individuals Enrolled in a Plan that has been Identified by CMS as a Consistent Poor Performer. In addition, plans are able to verify another organization's LPI status via the Medicare Plan Finder or the released Star Rating summary report. As a result, we do not see a reason to delay the offering of these two new SEPs until contract year 2022.

SEP for Significant Change in Provider Network

Comment: A commenter suggested that CMS revise this SEP so that it may be used when an individual plan enrollee's provider is terminated without cause, adding that while there is an existing SEP for significant change in an MA provider network, it is only triggered when a threshold of terminations is met. The commenter states that an individual may have joined a plan specifically because their provider contracts with it, or have developed a relationship with that provider they wish to maintain.

Response: We appreciate the comment. As stated in the proposed rule, CMS considers significant changes to provider networks to be those that go beyond individual or limited provider terminations that occur during the routine course of plan operations. CMS appreciates that an individual would want to maintain a relationship with an individual provider, however, an individual provider's termination from a plan would not disrupt or affect that enrollee's continued access to covered benefits. CMS continues to believe this SEP is best reserved for network changes that are significant and have the potential to affect the access of covered benefits for a large number of enrollees.

SEP for Individuals with ESRD Whose Medicare Entitlement Determination Was Made Retroactively

Comment: Two commenters supported the proposal to codify a SEP for individuals with ESRD whose Medicare entitlement determination was made retroactively because it would allow beneficiaries to enroll who were not able during the customary period, as well as ensure that beneficiaries may enroll into an MA plan if certain conditions are met prior to the MA ESRD enrollment rule taking effect in 2021. Both commenters recommended that educational outreach be made to individuals with ESRD.

Response: We appreciate the commenters' support and agree that education and outreach are essential for individuals to understand their enrollment options. We will continue to partner with existing stakeholders to ensure that clear and comprehensive information is provided to beneficiaries so they are able to make an informed coverage choice.

SEP for Other Exceptional Circumstances

Comment: A commenter expressed strong support for CMS' statement that it retains the ability to grant case-by-case exceptional circumstance SEPs, and that the list at § 422.62(b)(26) is not exhaustive. The commenter expressed concern that leaving the creation of new SEPs solely to rulemaking will mean that it will take longer to implement new, necessary SEPs should the need arise and will make the agency's response less nimble and may hinder its ability to quickly meet the needs of beneficiaries. The commenter urges CMS to reiterate, or otherwise educate, plan sponsors, 1–800–MEDICARE counselors and CMS staff that despite exceptional circumstance SEPs now being codified, that such discretion still exits.

Response: We appreciate the commenters' support and continue to believe that it is important to retain the discretion to establish SEPs on a case-by-case basis. As such, at newly redesignated § 422.62(b)(26) and newly redesignated § 423.38(c)(34), we are finalizing our proposal to codify a SEP for other exceptional circumstances, which are, as stated in the proposed rule, situations in which it is in the best interest of the beneficiary that she or he be provided an enrollment (or disenrollment) opportunity. To date, CMS has used the existing authority at §§ 422.62(b)(4) and 423.38(c)(8)(ii) to assist individuals whose unique situations are outside the parameters of the existing SEPs, in order to address an individual's exceptional circumstances related to new enrollments or enrollment/disenrollment from an MA or Part D plan. These SEPs, which we also refer to as enrollment exceptions, are utilized when the reason is not captured in an existing SEP or specific circumstances require an exception to the predefined criteria. Consistent with current practice, CMS will consider granting an enrollment exception when one or more of the following factors is present:

++ Extraordinary Circumstances—Circumstances beyond the beneficiary's control that prevented him or her from submitting a timely request to enroll or disenroll from a plan during a valid enrollment period. This is inclusive of, but not limited to, a serious medical emergency of the beneficiary or their authorized representative during an entire election period, a change in hospice status, or mailed enrollment forms returned as undeliverable on or after the last day of an enrollment period.

++ Erroneous Election—Situations in which a beneficiary provides a verbal or written allegation that his or her enrollment in a MA or Part D plan was based upon misleading or incorrect information provided by a plan representative or State Health Insurance Assistance Program (SHIP) counselor, including situations where a beneficiary states he or she was enrolled into a plan without his or her knowledge or consent, and requests cancellation of the enrollment or disenrollment from the plan.

++ Plan Accessibility—A SEP may be warranted to ensure beneficiary access to services and where without the approval of an enrollment exception, there could be adverse health consequences for the beneficiary. This is inclusive of, but not limited to, maintaining continuity of care for a chronic condition and preventing an interruption in treatment.

CMS will review supporting details and documentation to determine eligibility for the SEP for exceptional circumstances, which, as currently implemented, can be in response to an individual beneficiary's request for an exception to the current enrollment rules, as well as CMS' determination that an exception is warranted for a group of beneficiaries. The SEP would take effect once CMS makes its determination and the enrollee has been notified. The effective date for an enrollment or disenrollment election using an approved enrollment exception would be based on the beneficiary's circumstances and may either be prospective or retroactive.

In addition to proposing to codify SEPs established in sub-regulatory guidance, as well as proposing two new SEPs (related to plans placed into receivership or being identified as a consistent poor performer), we requested comments on other SEPs that should be considered for codification. In response to that request, we received the following feedback:

Comment: A commenter urged us to establish a SEP for individuals in MA or Part D plans who are impacted by significant changes in their plan benefits from one year to the next, for example, significantly higher premiums or reduced benefits. They believed that this was particularly important for individuals with standalone PDPs since they do not have the same option to change plans during the first three months of the year afforded to those who begin the year enrolled in an MA plan (pursuant to the MA OEP). The commenter stated that most people who are enrolled in a given plan tend to rely on that plan remaining more or less the same, and, as a consequence, many people do not carefully scrutinize their Annual Notice of Change (ANOC) or other plan documents describing annual changes.

Response: Every Fall, CMS conducts a robust educational campaign that urges beneficiaries to review their plan benefits and make changes if their plan no longer meets their needs or if there are other options that could lower their out-of-pocket expenses. The ANOC is an important resource that plans are required to send to members detailing how benefits will change in the next plan year. Ultimately, it is the beneficiary's responsibility to assess their own drug and healthcare needs and determine if there is a better plan for them. We appreciate the commenter's concern, but will not be finalizing the suggested SEP.

Comment: Two commenters recommended that we establish a SEP for beneficiaries who have been accepted for admission to, or have been admitted to, an extended neoplastic disease care hospital and a physician has noted that the individual has life expectancy of ninety days or less. The commenters stated that this was important because individuals who are diagnosed with advanced cancer are often at the end of their lives and should be able to disenroll from their MA plan to Original Medicare if the hospital where they choose to receive their care is outside of the plan's network. The commenters also noted that, as an alternative or an addition, CMS should determine extended neoplastic disease care hospitals to be ''institutions'' so that beneficiaries would be eligible for the Open Enrollment Period for Institutionalized Individuals (OEPI). The commenters noted that if this change was made, an additional revision should be made to waive the 90-day length of stay requirement.

Response: While we understand and are sympathetic to beneficiaries diagnosed with advanced cancer, we do not believe that the establishment of a new SEP is an appropriate remedy to this very specific situation. When establishing (and now codifying) SEPs, we look for broad scenarios where we believe it is imperative that beneficiaries have opportunities to join, change, or disenroll from plans. Beneficiaries who are not able to disenroll from their MA plan to return to Original Medicare still have access to Medicare Part A and Part B benefits. MA plans are required to cover all services covered by Original Medicare and if a member needs covered medical care that the providers in the plan's network cannot provide, the plan must cover care from an out-of-network provider.

The absence of neoplastic disease care hospitals from the list of facilities considered to be institutions is outside the scope of this proposal.

Comment: A commenter requested that we codify two SEPs that are in Chapter 2 of the Medicare Managed Care manual that were not included in the proposed SEPs in 42 CFR part 422: The SEP for Dual-Eligible Individuals and Other LIS Eligible Individuals and the SEP for CMS and State-Initiated Enrollments. Similarly, they also requested that we codify two SEPs in Chapter 3 of the Medicare Prescription Drug Benefit Manual that were not included in the proposed SEPs in 42 CFR part 423: The SEP for Full-Benefit Dual Individuals with Retroactive Uncovered Months and the SEP for Individuals Involuntarily Disenrolled

from an MA–PD plan due to loss of Part B.

Response: We appreciate the comments. The commenter requests that we codify in the Part C regulations the SEP for Dual-Eligible Individuals and Other LIS Eligible Individuals that is included in Chapter 2 of the Medicare Managed Care Manual. We disagree that this SEP should be codified as a Part C SEP, as it is included in the Part C enrollment guidance merely as a reiteration of an already existing Part D SEP at § 423.38(c)(4). To codify this in the Part C regulations would result in the establishment of additional election periods that we did not intend to establish. The basis for the existing SEP for Dual-Eligible Individuals and Other LIS Eligible Individuals is the fact that the beneficiary is (or has been) receiving the Part D low income subsidy, which is specific to Part D and why the SEP is codified in 42 CFR part 423 and not proposed as a SEP in part 422. Therefore, we decline to codify a SEP for Dual-Eligible Individuals and Other LIS Eligible Individuals in the Part C regulations.

The commenter also requests that we codify in the Part C regulations the SEP for CMS and State-Initiated Enrollments that is included in Chapter 2 of the Medicare Managed Care Manual. This SEP is based on § 422.60(g)(5), which states that individuals who are passively enrolled by CMS into an MA–PD plan are eligible for the Part D SEP described in § 423.38(c)(10). To codify a new Part C SEP would be redundant; therefore, we decline the commenter's request to do so.

The commenter also requests that we codify in the Part D regulations the SEP for Full-Benefit Dual Eligible Individuals with Retroactive Uncovered Months that is included in Chapter 3 of the Medicare Prescription Drug Benefit Manual. As described in guidance, this SEP addresses the scenario in which a Part D eligible individual needs prescription drug coverage through the Limited Income Newly Eligible Transition (LI NET) program prior to his or her enrollment in a Part D plan, either by submitting an application to a plan or by being auto-enrolled by CMS into a plan for a future date. Since the process for establishing retroactive drug coverage through LI NET is a CMS-directed process, and does not involve an individual taking action to request enrollment in a plan, we did not propose to codify this SEP, and we decline to do so in this final rule.

Lastly, the commenter requests that we codify in the Part D regulations the SEP for Individuals Involuntarily Disenrolled from an MA–PD plan due to loss of Part B that is included in Chapter 3 of the Medicare Prescription Drug Benefit Manual. As described in subregulatory guidance, individuals who are involuntarily disenrolled from an MA–PD plan due to loss of Part B but who continue to be entitled to Part A have a SEP to enroll in a PDP. The SEP begins when the individual is advised of the loss of Part B and continues for two additional months. We agree with the commenter that this SEP should be codified; the fact that it was not included in the proposed rule was an oversight. In response to this comment, we will codify at § 423.38(c)(33) the SEP for Individuals Involuntarily Disenrolled from an MA–PD plan due to loss of Part B.

In addition to comments received on specific SEPs and suggested SEPs, we also received the general comments discussed below.

Comment: A commenter recommended that CMS codify its guidance from Chapter 2 of the Medicare Managed Care Manual (MMCM), section 30.4, that an organization is not required to contact an applicant to confirm SEP eligibility if the enrollment request includes the applicant's attestation of SEP eligibility. The commenter stated that codifying this guidance would be particularly helpful in instances where the SEP is based on factual circumstances such as the beneficiary's former plan is placed in receivership or has been consistently poor performing, and the beneficiary attestation is the easiest source of the information.

Response: In codifying these SEPs, we focused on what the SEPs were and detailed the situations when they would be applicable. We did not include in the proposed rule the codification of subregulatory guidance regarding attestation of SEP eligibility. We believe that details concerning the operational processing of enrollment requests are better suited for sub-regulatory guidance where we are able to go into more detail and provide examples and context. As such, we are declining the commenter's recommendation to codify guidance related to beneficiary attestations.

Comment: A commenter urged CMS to also consider that some beneficiaries may experience financial or enrollment difficulties stemming from the COVID–19 disruption. Concerned that some beneficiaries who have temporarily lost their Part B coverage for non-payment of premium may miss their opportunity to enroll through the open enrollment that ended in March 2020 due to staffing disruptions at local social security offices.

Response: We are aware that given the ongoing COVID–19 pandemic, stakeholders are looking for flexibilities for all aspects of Medicare enrollment and entitlement. However, it appears that the commenter is providing feedback regarding Medicare Part B enrollment and associated rules in 42 CFR part 407. We did not include in the proposed rule any new or revised regulations regarding Part B enrollment periods or loss of Part B coverage for non-payment of premium. We thank the commenter for their insights, but decline to address or modify any Part B enrollment rules given that they are outside the scope of this rulemaking.

Comment: A commenter stated that CMS should clarify whether the effective date for certain SEPs should be the first of the month following when the request is made. The commenter referenced SEPs such as the SEP for Individuals Who Disenroll in Connection with a CMS Sanction, the SEP for Individuals in PACE or the SEP for Individuals Who Dropped a Medigap Policy When They Enrolled For the First Time in an MA Plan and Who are Still in a ''Trial Period.'' In addition, another commenter requested that we clarify the effective date for enrollment requests the organization receives from individuals eligible for the SEP for Individuals Whose Medicare Entitlement Determination Made Retroactively. As stated in the proposed rule, the effective date is the first day of the month following the MA organization's receipt of the election, but cannot be earlier than the first day of the month in which the notice of the Medicare entitlement determination is received by the individual. The commenter recommends that CMS permit retroactive enrollment based on when the beneficiary receives the notice of entitlement.

Response: We proposed to specify at §§ 422.68(d) and 423.40(c) that the effective date for elections made using SEPs described in §§ 422.62(b) and 423.38(c) is the first day of the calendar month following the month in which the election is made, unless otherwise noted. This applies to the SEP for Individuals Whose Medicare Entitlement Determination Made Retroactively as well, since it is not until an individual is notified of the Medicare entitlement determination that he or she, or an MA or Part D plan sponsor for that matter, would be aware of the determination and the Part A and/or Part B effective dates. We therefore disagree with the commenter that CMS should permit an enrollment to be retroactive to a date prior to when an individual received notification of

Medicare entitlement or prior to the date the individual requests enrollment in the plan.

After considering the public comments, we are finalizing all MA SEPs as proposed, with the exception of the *SEP for Individuals Affected by a FEMA-Declared Weather-Related Emergency or Major Disaster* at § 422.68(b)(18), which will be renamed the *SEP for Government Entity-Declared Disaster or Other Emergency.* This paragraph is being revised to change the scope of the SEP so that it applies to FEMA-declared emergencies, as well as emergency declarations issued by a federal, state or local government entity. We are also specifying in this paragraph that the SEP will—

- Start as of the date the declaration is made, the incident start date or, if different, the start date identified in the declaration, whichever is earlier; and
- End 2 full calendar months following the end date identified in the declaration or, if different, the date the end of the incident is announced, whichever is later.

In addition, we are adopting without modification the minor editorial changes in § 422.62(b) and (c) and the changes proposed at § 422.68 regarding effective dates of the SEPs.

2. Part D Special Election Periods (§ 423.38)

Section 1860D–1(b)(3) of the Act establishes special election periods (SEPs) during which, if certain circumstances exist, an individual may enroll in a stand-alone Part D prescription drug plan (PDP) or disenroll from a PDP and enroll in another PDP or in an MA plan that includes Part D benefits (MA–PD plan). We have codified SEPs for the following circumstances, which are explicitly discussed in the Act:

- SEP for Involuntary Loss of Creditable Prescription Drug Coverage.
- SEP for Individuals Not Adequately Informed about Creditable Prescription Drug Coverage.
- SEP for Enrollment/Non-enrollment in Part D due to an Error by a Federal Employee.
- SEP for Dual- and Other LIS-Eligible Individuals.
- SEP for MA–PD enrollee using the MA SEP65.

Section 1860D–1(b)(1)(B) of the Act directs us to adopt enrollment rules ''similar to (and coordinated with)'' those under Part C. Accordingly, in addition to those SEPs as previously described, we have applied certain SEPs established under the MA program to the Part D program. The SEPs from the MA program that have been codified for Part D include the following:

- SEP for Non-renewals or Terminations.
- SEP for Changes in Residence.
- SEPs for Contract Violation.

Section 1860D–1(b)(3)(C) of the Act also grants the Secretary the authority to create SEPs for individuals who meet other exceptional conditions, which is reflected at § 423.38(c)(8)(ii). Pursuant to this authority, we have previously codified SEPs for the following circumstances:

- SEP for Individuals Who Gain, Lose, or Have a Change in their Dual or LIS-Eligible Status.
- SEP for CMS and State-Initiated Enrollments.

CMS proposed to codify the following SEPs for exceptional circumstances, which are currently outlined in subregulatory guidance. Except as was noted in the proposed rule, our intent was to codify the current policy, and we solicited specific comment as to whether we overlooked any feature of the current policy that should be codified and if there were other exceptional circumstances we did not identify for which we should consider establishing a special election period.

We also proposed to revise § 423.40(c) to clarify that for SEPs that are described in § 423.38(c), elections are effective as of the first day of the first calendar month following the month in which the election is made, unless otherwise noted. In addition, we noted that, consistent with longstanding subregulatory guidance, the organization is not required to contact an applicant to confirm SEP eligibility if the enrollment request includes the applicant's attestation of SEP eligibility.

The proposed Part D SEPs are summarized below. (Readers should refer to the proposed rule for more detail on these SEPs.

SEP for Employer/Union Group Health Plan (EGHP) elections. At new § 423.38(c)(11), we proposed to codify that individuals making enrollment requests into or out of employer sponsored Part D plans (PDPs), for individuals to disenroll from a PDP to take employer sponsored coverage of any kind, and for individuals disenrolling from employer sponsored coverage (including COBRA coverage) would be eligible for a SEP to elect a PDP.

SEP for Individuals Who Disenroll in Connection with a CMS Sanction. At new § 423.38(c)(12), we proposed to codify the SEP for individuals enrolled in a PDP offered by a Part D plan sponsor that is sanctioned by CMS.

SEP for Individuals Enrolled in Cost Plans that are Non-renewing their Contracts. At new § 423.38(c)(13), we proposed to codify the SEP for individuals enrolled in cost plans that are non-renewing their contracts for the area in which the enrollee lives.

SEP for Individuals in the Program of All-inclusive Care for the Elderly (PACE). At new § 423.38(c)(14), we proposed to codify the SEP allowing individuals to disenroll from a PDP at any time in order to enroll in PACE.

SEP for Institutionalized Individuals. At new § 423.38(c)(15), we proposed to codify the SEP allowing individuals who move into, reside in, or move out of an institution, as defined at § 422.2, to enroll in or disenroll from a PDP.

SEP for Individuals Who Enroll in Part B during the Part B General Enrollment Period (GEP). At new § 423.38(c)(16), we proposed to codify the SEP for individuals who are not entitled to premium free Part A and who enroll in Part B during the GEP for Part B (January–March) for an effective date of July 1st to enroll in a PDP.

SEP for Individuals Who Belong to a Qualified SPAP or Who Lose SPAP Eligibility. At new § 423.38(c)(17), we proposed to codify a SEP for individuals who belong to a qualified SPAP to make one election to enroll in a Part D plan each calendar year.

SEP for Disenrollment from Part D to Enroll in or Maintain Other Creditable Coverage. At new § 423.38(c)(18), we proposed to codify the SEP that provides an opportunity for individuals to disenroll from a Part D plan in order to enroll in or maintain other creditable drug coverage (such as TriCare or VA coverage) as defined in § 423.56(b).

SEP for Individuals Disenrolling from a Cost Plan who also had the Cost Plan Optional Supplemental Part D Benefit. At new § 423.38(c)(19), we proposed to codify that individuals who disenroll from a cost plan and the cost plan's optional supplemental Part D benefit would have a SEP to enroll in a PDP.

SEP to Enroll in a PDP with a Star Rating of 5 Stars. At new § 423.38(c)(20), we proposed to codify the SEP allowing an eligible individual to enroll in a PDP with a Star Rating of 5 stars during the plan contract year in which that plan has the 5-star overall rating.

SEP for Non-U.S. Citizens who become Lawfully Present. At § 423.38(c)(21), we proposed to codify the SEP for non-U.S. citizens who become lawfully present in the United States.

SEP for Providing Individuals who Requested Materials in Accessible Formats Equal Time to Make Enrollment

Decisions. At § 423.38(c)(22), we proposed to codify the SEP in situations where the Part D plan sponsor or CMS was unable to provide required notices or information in an accessible format, as requested by an individual, within the same timeframe that it was able to provide the same information to individuals who did not request an accessible format.

SEP for Individuals Affected by a FEMA-Declared Weather Related Emergency or Major Disaster. At § 423.38(c)(23), we proposed to codify the SEP for individuals affected by a weather-related emergency or major disaster who were unable to make an election during another valid election period.

SEP for Individuals Enrolled in a Plan Placed in Receivership. We proposed to establish a new SEP, at new § 423.38(c)(31), for individuals enrolled in a Part D plan offered by a plan sponsor that is experiencing financial difficulties to such an extent that a state or territorial regulatory authority has placed the sponsor in receivership.

SEP for Individuals Enrolled in a Plan that has been Identified by CMS as a Consistent Poor Performer. We proposed to establish a new SEP, at new § 423.38(c)(32), for individuals who are enrolled in plans identified with the low performing icon (LPI) in accordance with § 423.186(h)(1)(ii).

SEP for Other Exceptional Circumstances. We proposed to retain the authority currently at § 423.38(c)(8)(ii) to create SEPs for individuals who meet other exceptional conditions established by CMS and move it to new § 423.38(c)(34).

Also based on the Secretary's authority to create SEPs for individuals who meet exceptional conditions, we proposed to codify the following SEPs currently outlined in manual instructions that coordinate with Part C election periods:

SEP for Individuals Who Terminated a Medigap Policy When They Enrolled For the First Time in an MA Plan, and Who Are Still in a Trial Period. We proposed to codify at new § 423.38(c)(24) a coordinating Part D SEP for individuals who disenrolled from their MA plan during their trial period (and have guaranteed issue rights).

SEP for an Individual using the MA Open Enrollment Period for Institutionalized Individuals (OEPI) to Disenroll from a MA–PD plan. At new § 423.38(c)(25), we proposed to codify that an individual disenrolling from an MA–PD plan has a SEP to request enrollment in a PDP.

Medicare Advantage Open Enrollment Period (MA OEP). At new § 423.38(c)(26), we proposed to codify that MA enrollees using the MA OEP would have a SEP to add or change Part D coverage.

SEP to request enrollment into a PDP after loss of special needs status or to disenroll from a PDP in order to enroll in an MA SNP. At new § 423.38(c)(27), we proposed to codify the SEP to request enrollment in a PDP for those who are no longer eligible for a SNP because they no longer meet the plan's special needs criteria.

SEP for Enrollment into a Chronic Care SNP and for Individuals Found Ineligible for a Chronic Care SNP. At proposed § 423.38(c)(28), we proposed to codify the SEP for both Part C and Part D for those individuals with severe or disabling chronic conditions to enroll in a Chronic Care SNP (C–SNP) designed to serve individuals with those conditions.

SEP for Individuals Using the 5-Star SEP to Enroll in a 5-Star Plan without Part D Coverage. At new § 423.38(c)(29), we proposed to codify that individuals who use the 5-star SEP we proposed to be codified at § 422.62(b)(15) to enroll in a 5-star MA plan that does not include Part D benefits or a 5-star cost plan would have a SEP to enroll in a PDP or in the cost plan's optional supplemental Part D benefit.

SEP to enroll in a PDP for MA enrollees using the ''SEP for Significant Change in Provider Network'' to disenroll from an MA Plan. We proposed to codify at new § 423.38(c)(30) that MA enrollees using the ''SEP for Significant Change in Provider Network'' to disenroll from an MA plan (proposed at § 422.62(b)(23)) would be able to request enrollment in a PDP.

The revisions we proposed would codify existing subregulatory guidance for SEPs that Part D sponsors have previously implemented and are currently following, except for the *SEP for Individuals Enrolled in a Plan Placed in Receivership* and the *SEP for Individuals Enrolled in a Plan that has been Identified by CMS as a Consistent Poor Performer.* We also proposed a few minor editorial changes in § 423.38(c), such as changing ''3'' to ''three.''

While most of the comments received on our SEP proposals related to SEPs that are applicable to both MA and Part D and, thus, were addressed above, we did receive one Part D-specific SEP comment.

Comment: While commenting on the proposed SEPs, a few commenters requested that we revisit the changes to the dual SEP finalized in April 2018 (83 FR 16514), when this SEP was changed from a monthly SEP to one that allows an individual to enroll in, or disenroll from, an MA plan once per calendar quarter during the first nine months of the year. A commenter stated that an ongoing SEP for dual eligible individuals to enroll in either a FIDE SNP or a HIDE SNP would provide greater choice and access to integrated care options. Other commenters believed these beneficiaries needed the flexibility to change their healthcare coverage at any time during the year and viewed the previous ongoing dual SEP as an important beneficiary protection.

Response: As we noted in the April 2018 final rule, we understood that many commenters preferred an ongoing dual SEP, but we believed that adopting limitations was an appropriate step toward encouraging care coordination, achieving positive health outcomes, and discouraging extraneous beneficiary movement during the plan year. We were—and continue to be—mindful of the unique health care challenges that dual and other LIS-eligible beneficiaries may face. Under the revised rules, dual and other LIS-eligible beneficiaries continue to have additional flexibilities not afforded to other Part D-eligible beneficiaries and are able to make elections during the year. Given that our overall goals of improving administration of benefits and coordination of care have not changed, and we believe that continuity of enrollment helps us achieve these goals, we will not be revising the dual SEP at this time.

After considering the public comments, we are finalizing all SEPs as proposed, with the exception of the following:

- The SEP for Individuals Affected by a FEMA-Declared Weather-Related Emergency or Major Disaster at § 423.38(c)(23) will be renamed the SEP for Government Entity-Declared Disaster or Other Emergency. This paragraph is being revised to change the scope of the SEP so that it applies to FEMA-declared emergencies/disasters, as well as disaster or other emergency declarations issued by a federal, state or local government entity. We are also specifying in this paragraph that the SEP will—
  - Start as of the date the declaration is made, the incident start date or, if different, the start date identified in the declaration, whichever is earlier; and
  - End 2 full calendar months following the end date identified in the declaration or, if different, the date the end of the incident is announced, whichever is later. This 2 month period

is consistent with other longstanding SEPs.

- As discussed in the MA SEP section, at § 423.38(c)(33) we are codifying the SEP for Individuals Involuntarily Disenrolled from an MA–PD plan due to loss of Part B. This SEP is currently in subregulatory guidance, but was inadvertently omitted from the proposed rule.
- We are designating the SEP for Other Exceptional Circumstances from proposed § 423.38(c)(33) to § 423.38(c)(34).

In addition, we are adopting without modification the minor editorial changes in § 423.38(c) and the changes proposed at § 423.40 regarding effective dates of the SEPs.

VI. Technical Changes

A. Advance Notice and Announcement of Part D Risk Adjustment Factors (§ 423.329)

The Part D statute, and the regulations implementing the statute, specify that we must publish the Part D risk adjustment factors at the time of publication of the Part C risk adjustment factors (section 1860D–15(c)(1)(D) of the Act and § 423.329(b)(4)). We proposed to amend § 423.329(b)(4) to stipulate our intention to publish Part D risk adjustment factors using the process through which we would adopt, and announce the capitation rates and risk adjustment methodology for the MA program (section 1853(b)(1)(B) of the Act and § 422.312(a)(1)(ii)).

The existing regulation codifying section 1860D–15(c)(1)(D) of the Act mirrors the statutory language of publishing Part D risk adjustment at the time of Part C risk adjustment factor publication but does not specify the means by which CMS will do so. In the vein of the MMA, which added a new ''Part D'' to the Medicare statute (sections 1860D–1 through 42 of the Act), and directed that important aspects of the Part D program be similar to, and coordinated with law for, the MA program, CMS interpreted section 1860D–15(c)(1)(D) of the Act to mean that Part D risk adjustment factors should be published as part of the Advance Notice and Rate Announcement process used for Part C (section 1853(b)(1)(B) of the Act and § 422.312(a)(1)(ii)). This amendment revises the regulation text to clarify our interpretation of the statute under which we will continue to publish Part D risk adjustment factors through the Advance Notice and Rate Announcement process. This final rule codifies the current interpretation of the statutory requirement and will not change how we propose and finalize the Part D risk adjustment model.

We did not receive comments on this proposal and therefore are finalizing this provision without modification.

B. Advance Notice and Announcement of Part C Annual Capitation Rate, Benchmarks, and Methodology Changes (§ 422.312)

In the February 18, 2020 proposed rule, we proposed a technical change to align the timeframes identified in § 422.312(b)(1) and (2) with the current statutory text (section 1853(b) of the Act). Section 1853(b) of the Act specifies the process through which we propose, adopt, and announce changes in risk adjustment methodology and capitation rates for the MA program. When first written, section 1853(b)(2) of the Act called for a 45-day advance notice period for the annual capitation rate and factors (for example, risk) used to adjust those rates and did not explicitly address a minimum comment period. However, the Securing Fairness in Regulatory Timing Act of 2015 (Pub. L. 114–106) (SFRTA) amended section 1853(b) of the Act to require a 60-day advance notice period and a 30-day comment period.

The regulation implementing the advance notice and comment period, as written, mirrors the statute's original timeframe for issuance of the advance notice and requires only a 15-day comment period. While CMS adjusted operational practices to comply with current statutory requirements, we did not update the CFR provision. In this final rule, we update the advance notice of changes in methodology requirements at § 422.312(b)(1) and (2) by revising paragraph (b)(1) to refer to 60 days and paragraph (b)(2) to refer to 30 days, as stated in statute.

Comment: A commenter supported the proposal to revise the timeframes to follow the current statute to provide a 60-day advance notice period and a 30-day comment period. The commenter believes the 60-day timeframe allows more time for analysis and comment on methodology changes, including risk adjustment in MA.

Response: We thank the commenter for their support. We are finalizing this provision as proposed without modification.

VII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a ''collection of information,'' as defined under 5 CFR 1320.3(c) of the PRA's implementing regulations, is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection requirement should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

In our February 18, 2020, proposed rule (85 FR 9002), we solicited public comment on our proposed information collection requirements, burden estimates, and assumptions. We did not receive any such public comments as it pertains to the proposed information collection requirements, burden estimates, and assumptions that are being finalized in this rule.

However, five changes were made to this section based on our further consideration of these issues:

- We have added section VII.B.1. of this final rule specifically addressing information collection requirements regarding SSBCI.
- Section VII.A. of this final rule reflects wage updates for 2019 as well as the differences between the 2019 and 2018 rates. The changes in Table 2 were then used to update the estimates for each of the provisions.
- As discussed more fully in section VII.B.3. of this final rule regarding the impact of the ESRD provision, CMS expects a shortened enrollment form to be available starting in 2021. This enrollment form is expected to reduce the time burden for completing an enrollment form from 30 minutes to 20 minutes. This reduction affects the impacts of several provisions in this section.
- As discussed in the next few paragraphs, and as further detailed in the provisions whose impact is estimated in this section, the implementation of certain provisions finalized in this rule will be delayed compared to the proposal. This has resulted in recalculations that are specific to several provisions and discussed as appropriate in the respective sections.
- The implementation date for the contract limitation on existing D–SNP look-alikes finalized in § 422.514(d) has been delayed one year, as discussed in

section II.B of this final rule. As a result, we assume that the burden related to this provision will take place over the two years prior to the implementation rather than one year, as we assumed in the proposed rule. The details are provided later in this section.

- This final rule does not finalize all provisions in the proposed rule. Given the need to focus our attention on more immediate regulatory actions, this final rule implements a subset of the provisions that were proposed in the February 2020 proposed rule. In this regard, we are limiting this rule to this set of provisions. The remaining proposals will be addressed in a separate final rule that we expect to publish later in 2020. Thus, the collection of information requirements are expected to be addressed as follows:
- Rule Number 1: PRA-related Requirements/Burden Finalized in this Rule
  - ++ Special Supplemental Benefits for the Chronically Ill (SSBCI) (§ 422.102)
  - ++ Contracting Standards for Dual Eligible Special Needs Plan (D–SNP) Look-Alikes (§ 422.514)
  - ++ Medicare Advantage (MA) Plan Options for End-Stage Renal Disease (ESRD) Beneficiaries (§§ 422.50, 422.52, and 422.110)
  - ++ Medical Loss Ratio (MLR) (§ 422.2440)
  - ++ Special Election Periods (SEPs) for Exceptional Conditions (§§ 422.62 and 423.38)
- Rule Number 2: PRA-related Requirements to be Addressed Later in 2020
  - ++ Improvements to Care Management Requirements for Special Needs Plans (SNPs) (§ 422.101)
  - ++ Mandatory Drug Management Programs (DMPs) (§ 423.153)
  - ++ Beneficiaries with History of Opioid-Related Overdose Included in Drug Management Programs (DMPs) (§ 423.100)
  - ++ Eligibility for Medication Therapy Management Programs (MTMPs) (§ 423.153) and Information on the Safe Disposal of Prescription Drugs
  - ++ Beneficiaries' Education on Opioid Risks and Alternative Treatments (§ 423.128)
  - ++ Suspension of Pharmacy Payments Pending Investigations of Credible Allegations of Fraud and Program Integrity Transparency Measures (§§ 405.370, 422.500, 422.503, 423.4, 423.504, and 455.2)
  - ++ Beneficiary Real Time Benefit Tool (RTBT) (§ 423.128)
  - ++ Establishing Pharmacy Performance Measure Reporting Requirements (§ 423.514)
  - ++ Service Delivery Request Processes under PACE (§§ 460.104 and 460.121)
  - ++ Appeals Requirements under PACE (§§ 460.122 and 460.124)
  - ++ Documenting and Tracking the Provision of Services under PACE (§ 460.98)
  - ++ Documentation in Medical Records under PACE (§ 460.210)
  - ++ PACE Participant Rights: Contact Information and Access Requirements (§ 460.112)
  - ++ Stipulated Decisions in Part C (§ 422.562)

A. Wage Data

To derive average costs, we are using data from the U.S. Bureau of Labor Statistics' (BLS's) May 2019 National Occupational Employment and Wage Estimates for all salary estimates (*http://www.bls.gov/oes/current/oes_nat.htm*). In this regard, Table 1 presents the mean hourly wage, the cost of fringe benefits and overhead (calculated at 100 percent of salary), and the adjusted hourly wage.

TABLE 1—NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Mean hourly wage ($/hr)	Fringe benefits and overhead ($/hr)	Adjusted hourly wage ($/hr)
Actuaries	15–2011	58.16	58.16	116.32
All Occupations [used for impact on enrollees filling out forms].	00–0000	25.72	n/a	n/a
Business Operations Specialist, all others	13–1198	38.57	38.57	77.14
Compliance Officer	13–1041	35.03	35.03	70.06
Computer Programmers	15–1251	44.53	44.53	89.06
General Operations Manager	11–1021	59.15	59.15	118.30
Health Technician, All Other	29–9098	28.17	28.17	56.34
Office Support and Administrative Support	43–9199	18.41	18.41	36.82
Physician	29–1216	96.85	96.85	193.70

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer and because methods of estimating these costs vary widely from study to study. We believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Wages for Individuals: For beneficiaries, we believe that the burden will be addressed under All Occupations (at $25.72/hr) since the group of individual respondents varies widely from working and nonworking individuals and by respondent age, location, years of employment, and educational attainment, etc. Unlike our private sector wage adjustment, we are not adjusting this figure for fringe benefits and overhead since the individuals' activities will occur outside the scope of their employment.

Revised Wage and Cost Estimates: While our proposed rule's costs were based on BLS's May 2018 wages, this final rule uses BLS's May 2019 wages which are the most current as of the publication date of this rule. Changes to the adjusted wages represent shifts in average wages of occupations between 2018 and 2019 and are presented in Table 2. This table only contains wage estimates for occupations used in both the proposed rule and this final rule. However, provisions which were not estimated in the proposed rule but were estimated in the final rule require consideration of additional occupational titles beyond those in this table.

TABLE 2—COMPARISON OF PROPOSED AND FINALIZED ADJUSTED HOURLY WAGES

Occupation title	Occupation code	CMS–4190–P: May 2018 ($/hr)	CMS–4190–F: May 2019 ($/hr)	Difference ($/hr)
Actuaries	15–2011	111.78	116.32	+4.54
All Occupations *	00–0000	24.98	25.72	+0.74
Business Operations Specialist, all others	13–1198	74.00	77.14	+3.14
Compliance Officer	13–1041	69.72	70.06	+0.34
Computer Programmers	15–1251	86.14	89.06	+2.92
General Operations Manager	11–1021	119.12	118.30	−0.82
Health Technician, All Other	29–9098	50.90	56.34	+5.44
Office Support and Administrative Support	43–9199	36.04	36.82	+0.78
Physician	29–1216	202.86	193.70	−9.16

* Represents the mean hourly rate for individuals which, as explained above, is not adjusted for fringe benefits and overhead.

B. Information Collection Requirements (ICRs)

The following ICRs are listed in the order of appearance within the preamble (see sections II through VI) of this final rule.

1. ICRs Regarding Special Supplemental Benefits for the Chronically Ill (SSBCI) (§ 422.102)

As explained in section II.A. of this final rule, CMS is finalizing provisions for furnishing SSBCI. In section II.A. of this final rule, CMS adopts a regulation to implement section 1852(a)(3)(D) of the Act, which authorizes MA plans to furnish special supplemental benefits exclusively to chronically ill enrollees, as defined in the statute. SSBCI are currently allowed in 2020.

In this final rule, we are finalizing four SSBCI provisions with paperwork burden. We are finalizing the proposed requirements at § 422.102(f)(3) requiring MA plans offering SSBCI to: (i) Develop written policies for determining enrollee eligibility and document the determination that an enrollee is a chronically ill enrollee based on the definition in statute and regulation; (ii) make information and documentation related to determining enrollee eligibility available to CMS upon request; (iii) have written policies based on objective criteria for determining a chronically ill enrollee's eligibility to receive a particular SSBCI and document these criteria; and (iv) document each determination that an enrollee is eligible to receive an SSBCI and make this information available to CMS upon request. We address the collection of information in a reorganized fashion to address the functions that are required by the regulation as a whole rather than by how the regulation is structured and codified. We address these required MA organization functions and activities as follows:

In this final rule, we are finalizing four SSBCI provisions with paperwork burden. We are finalizing the proposed requirements at § 422.102(f)(3)(i) through (iv) requiring MA plans offering SSBCI to:

(1) Have written policies for determining enrollee eligibility to be considered chronically ill and must have written policies based on objective criteria for determining a chronically ill enrollee's eligibility to receive a particular SSBCI;

(2) document in writing the criteria for determining enrollee eligibility for being considered chronically ill and must also document in writing the enrollee's eligibility to receive a particular SSBCI;

(3) Make information and documentation related to determining enrollee eligibility available upon request;

(4) document each determination that an enrollee is eligible to receive an SSBCI, and make information concerning enrollee eligibility criteria available to CMS.

In this section, we estimate the paperwork burden of each of these four functions required by the final regulation. The following changes will be submitted to OMB for approval under control number 0938–0763 (CMS–R–262).

a. Per § 422.102(f)(3)(i), plans must have written policies for determining enrollee eligibility to be considered chronically ill and, per paragraph (f)(3)(iii), must have written policies based on objective criteria for determining a chronically ill enrollee's eligibility to receive a particular SSBCI.

Since the authority to offer and cover SSCBI is already being implemented, we assume most MA organizations already have developed the required policies since it would be difficult to score the cost in their bids without having such policies. We similarly assume that most plans have internal written memos documenting these criteria and that they have updated their systems to record enrollee eligibility for SSBCI (since without such documentation they would have no way of knowing when to reimburse providers for furnishing SSBCI to enrollees).

Therefore, this provision codifies existing practice.

However, even though we expect that the policies have already been developed, we have inadvertently neglected to account for the requirement and burden in any of our collection of information requests. We are correcting this oversight via this proposed and final rulemaking activity.

We estimate that it will take a team of one compliance officer (at $70.06/hr), one physician (at $193.70/hr), and one general operations manager (at $118.30/hr) a total of 5 hours to develop the necessary policies. The team's hourly cost is $382.06/hr ($70.06/hr + $193.70/hr + $118.30/hr). In aggregate, the annual burden for 234 parent organizations is 1,170 hours (234 plans * 5 hrs) at a cost of $447,010 (1,170 hr * $382.06/hr) or $1,910 ($447,010/234) per organization.

This is an annual requirement/burden since plan packages renew each year and the SSBCI criteria must therefore be reevaluated, including confirmation of existing criteria, each year.

b. Per § 422.102(f)(3)(i), plans must also document in writing those criteria for determining enrollee eligibility for being considered chronically ill and, per § 422.102(f)(3)(iii), must also document in writing the enrollee's eligibility to receive a particular SSBCI.

We estimate it will take 2 hours at $56.34/hr for a health technician to document in writing the objective criteria for determining an enrollee's eligibility to be considered chronically ill and to be eligible to receive a particular SSBCI. In aggregate, we estimate an annual burden of 468 hours (234 plans * 2 hr/plan) at a cost of $26,367 (468 hrs * $56.34/hr) or $113 per plan.

This is an annual requirement/burden since documentation must be performed each contract year.

c. Per § 422.102(f)(3)(iv), plans must also document each determination that an enrollee is eligible to receive an SSBCI and make this information available to CMS upon request. To date, MA organizations have only been able to include non-primarily health related SSBCI in the plan offerings since January 1, 2020, during one contract year (that is, 2020). While early indications show that utilization for these benefits have been low, we expect the use of these benefits to grow over time as MA organizations become more familiar with them and have time to include them in future plan offerings. Thus, our data is not indicative of future usage.

To offer SSBCI, a plan must determine, as defined in legislation, that an enrollee is chronically ill and that the items or services furnished under the SSBCI have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee. This determination would require a review of the enrollee's health records (for example, diagnosis codes, frequency of hospitalizations, and doctor's notes) as well as a determination and review by plan medical staff that the SSBCI has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.

Thus the process may be partially automated with the remainder of the process requiring medical review. We accordingly must account for three contributions to total impact:

(1) Initial creation of software, annualized over 3 years: Initially, software will be created to collect basic data elements (claims, diagnoses, hospitalizations, drug utilization) for physician review. We expect a team of three professionals: A compliance officer would identify categories of eligible SSBCI, the physician would identify needed data elements for review, and the computer programmer would automate this part of the process. We expect a burden of 2,808 hours (234 parent organizations times 12 hours (8 hours for a programmer plus 2 hours for a compliance officer plus 2 hours for a physician)) at an annualized cost of $96,717 ((⅓) times 2808 hours times a team wage of $103.33/hr ([8 hours times $89.06 (computer programmer) + (2 hours times 70.06 (compliance officer) + (2 hours times $193.70 (physician))]/12).

(2) Annual physician review of cases: We expect ongoing plan physician review in all years (including the first) to ascertain if the SSBCI is expected to have the desired impact on enrollees. We assume 3 hours of review per month per parent organization, resulting in 36 hours per parent organization per year. In aggregate, we expect a burden of 8,424 hours (234 parent organization times 36 hours per parent organization) at an annual burden of $1,631,729 (8,424 hours times $193.70/hr, physician wage).

(3) Annual update of software: It would clearly be overly burdensome to review each SSBCI case. Thus as cases are reviewed, we expect the continual review of new cases to generate additional criteria that can be automated. We assume half the time for updates as for the initial first-year creation. We assume a burden of 1,170 hours (234 parent organizations times 5 hours (1 hour for a compliance officer plus 4 hours for a computer programmer) at a cost of $99,754 (1170 hours times a team wage of $85.26/hr ([4 hours times $89.06 (computer programmer) plus 1 hour times $70.06 (compliance officer)]/5). Table 3 summarizes all burdens connected with SSBCI.

(4) Make information concerning enrollee eligibility criteria available to CMS.

We are not requiring MA plans to report or submit this information on a regular or consistent basis to CMS. We do not intend to closely monitor or regularly request this documentation and reiterate that MA plans will have discretion in designing which items and services to offer as SSBCI and for which chronically ill enrollees to cover them, so long as the statutory and regulatory standards are met. CMS intends to use this authority to collect information as necessary for program oversight, such as if there are specific, consistent, and/or severe complaints that an MA plan is violating the rules set forth in § 422.102(f). Based on our experience with serious plan complaints, we anticipate requesting no more than 5 plans per year to complete this task. Consequently, since this provision is expected to affect less than 10 entities per year, it is exempt from paperwork burden (5 CFR 1320.3(c)(4)). Table 3 summarizes the various burdens associated with SSBCI.

TABLE 3—SUMMARY OF BURDEN FOR SSBCI AT § 422.102

Provision	Regulatory citation	OMB Control No.	Subject	Number of respondents	Total number of responses	Time per response (hr)	Total time (hr)	Labor cost ($/hr)	Annual cost ($)
SSBCI	422.102(f)(3)(i)		SSBCI: Criteria (Initial Software).	234	1	12	2808	103.33	96,717
SSBCI	422.102(f)(3)(i)		SSBCI: Criteria (Physician review).	234	1	36	8424	193.7	1,631,729
SSBCI	422.102(f)(3)(i)		SSBCI: Criteria (Software updates).	234	1	5	1170	85.26	99,754
SSBCI	422.102(f)(3)(ii)		Written criteria	234	1	2	468	56.34	26,367
SSBCI	422.102(f)(3)(iii)		Enrollee eligibility	234	1	9	2106	86.95	179,465
Total				234		Varies	14,976		2,034,032

2. ICRs Regarding Contracting Standards for Dual Eligible Special Needs Plan (D–SNP) Look-Alikes (§ 422.514)

The following changes will be submitted to OMB for approval under control numbers 0938–0753 (CMS–R–267) and 0938–NEW (CMS–10718). The requirements under CMS–R–267 are associated with burden on MA plans identified as D–SNP look-alikes under § 422.514(d) and (e) (see section VII.B.1.a. of this final rule). The requirements under CMS–10718 are associated with burden on the enrollees in these MA plans (see section VII.B.1.b. of this final rule).

We did not receive any comments on our proposed collection of information requirements and burden estimates; however, we are updating our proposed burden estimates to reflect the change in this final rule delaying the prohibition on the renewal of existing D–SNP look-alikes by one year. As indicated above in section VII.A. of this final rule, we have also revised our proposed cost figures based on more recent BLS wage estimates.

As described in section II.B. of this final rule, we are establishing new contract requirements that we believe are necessary to fully implement federal D–SNP requirements, especially those related to Medicare-Medicaid integration codified at §§ 422.2, 422.107, and 422.629 through 422.634 pursuant to the BBA of 2018. We are finalizing a prohibition on CMS entering into a new contract for plan year 2022 and future years for any non-SNP MA plan that projects in its bid submitted under § 422.254 that 80 percent or more of the plan's total enrollment are enrollees entitled to medical assistance under a state plan under Title XIX of the Act. Additionally, we are finalizing a prohibition for plan year 2023 and future years on CMS renewing an existing contract for any non-SNP MA plan that an MA organization offers that has actual enrollment, as determined by CMS in January of the current year, consisting of 80 percent or more of enrollees who are entitled to medical assistance under a state plan under title XIX of the Act, unless the MA plan has been active for less than 1 year and has enrollment of 200 or fewer individuals at the time of such determination.

Our dually eligible enrollment threshold at § 422.514(d) will apply to any plan that is not a SNP as defined in § 422.2. We are applying this requirement only to non-SNP plans to allow for the disproportionate dually eligible enrollment that characterizes D–SNPs, institutional SNPs, and some chronic or disabling condition SNPs by virtue of the populations that the statute expressly permits each type of SNP to exclusively enroll. The requirement is also limited to states where there is a D–SNP or any other plan authorized by CMS to exclusively enroll dually eligible individuals, such as a Medicare-Medicaid Plan (MMP). We are establishing this limitation because it is only in such states that the implementation of D–SNP requirements necessitates our new contracting requirements. That is, in a state with no D–SNP or comparable managed care plan, the D–SNP requirements have not had any relevance historically, and therefore the operation of a D–SNP look-alike does not have any material impact on the full implementation of federal D–SNP requirements.

The contract requirement based on the projected enrollment in the plan bid at § 422.514(d)(1) will prevent MA organizations from designing new D–SNP look-alikes. Under at § 422.514(d)(2), we will make the determination whether an MA organization has an existing non-SNP MA plan with actual enrollment exceeding the established threshold using the enrollment in January of the current year. Using data from the most recently available contract year, the 2020 bid submission process, we estimate that there are 67 MA plans that have enrollment of dually eligible individuals that is 80 percent or more of total enrollment. Of these 67 MA plans, 62 plans are in 19 states [53] where there are D–SNPs or comparable managed care plans and will be subject to § 422.514(d). These 62 plans projected a total enrollment of 180,758 for contract year 2020.

MA organizations will likely non-renew for plan year 2022 or 2023 those plans that exceed our criteria in § 422.514(d)(1) and (2). The MA organization has the opportunity to make an informed business decision to transition enrollees into another MA–PD plan (offered by it or by its parent organization) by: (1) Identifying, or applying and contracting for, a qualified MA–PD plan, including a D–SNP, in the same service area; or (2) creating a new D–SNP through the annual bid submission process. We expect the vast majority of D–SNP look-alike enrollees to be transitioned into a plan offered by the same parent organization as the D–SNP look-alike, and we expect in rare instances that the non-renewing plan may choose to not transition enrollees.

The changes required of MA organizations based on this final rule impact D–SNP look-alikes (see section VII.B.1.a. of this final rule) and their enrollees (see section VII.B.1.b. of this final rule). While we cannot predict the actions of each affected MA organization with 100 percent certainty, we base our burden estimates on the current landscape of D–SNP look-alikes, the availability of D–SNPs or MA–PD plans under the same parent organization in the same service area, and the size and resources of the MA organization.

a. MA Plan Requirements and Burden

As indicated, the following changes will be submitted to OMB for approval under control number 0938–0753 (CMS–R–267). Subject to renewal, the control number is currently set to expire on December 31, 2021.

At § 422.514(e), we are finalizing a process for an MA organization with a D–SNP look-alike to transition individuals who are enrolled in its D–SNP look-alike to another MA–PD plan offered by the MA organization, or by another MA organization with the same parent organization as the MA organization, to minimize disruption as a result of the prohibition on contract renewal for existing D–SNP look-alikes. Under this final rule, an MA organization with a non-SNP MA plan determined to meet the enrollment threshold in § 422.514(d)(2) could transition enrollees into another MA–PD plan offered by the same MA organization (or by another MA organization with the same parent organization as the MA organization), as long as that receiving MA–PD plan meets certain criteria specified in § 422.514(e)(1)(i)–(iv). The process finalized at § 422.514(e) allows, but does not require, the MA organization to transition dually eligible enrollees from D–SNP look-alikes into D–SNPs and other qualifying MA–PD plans for which the enrollees are eligible without the transitioned enrollees having to complete an election form. This transition process is conceptually similar with the proposed ''crosswalk exception'' procedures at § 422.530(a) and (b) as described in the proposed rule; however, this final rule allows the transition process to apply across contracts or legal entities and from non-SNP to SNPs provided that the receiving plan is otherwise be of the same plan type (for example, HMO or PPO) as the D–SNP look-alike.

While the contract limitation for existing D–SNP look-alikes begins in the 2023 plan year, we intend for the transition process to take effect in time for D–SNP look-alikes operating in 2020 and 2021 to utilize the transition process for enrollments effective January 1, 2021 or January 1, 2022, respectively. Based on the current landscape for D–SNP look-alikes, we believe the vast majority of D–SNP look-alikes are able to move current enrollees into another MA–PD plan using the transition process we are finalizing in this rule. We expect many of these plans will choose to transition membership for the 2022 and 2023 plan years. Therefore, we are assuming the burden of the 62 plans transitioning enrollees will happen for half the plans in 2021 (for a 2022 effective date) and half the plans in 2022 (for a 2023 effective date).

We estimate each plan will take a one-time amount of 2 hours at $77.14/hr for a business operations specialist to submit all enrollment changes to CMS necessary to complete the transition process. D–SNP look-alikes that transition enrollees into another non-SNP plan will take less time than D–SNP look-alikes that transition eligible beneficiaries into a D–SNP because they will not need to verify enrollees'

[53] These 62 plans are located in Arizona, Arkansas, California, Hawaii, Idaho, Illinois, Indiana, Louisiana, Michigan, Mississippi, New Jersey, New Mexico, North Carolina, Ohio, Oregon, South Carolina, Tennessee, Utah, and Washington.

Medicaid eligibility. The 2-hour time estimate accounts for any additional work to confirm an enrollee's Medicaid eligibility for D–SNP look-alikes transitioning eligible enrollees to a D–SNP. The burden for MA organizations to transition enrollees to other MA–PD plans during the 2021 and 2022 plan years is 124 hours (62 D–SNP look-alikes * 2 hr/plan) at a cost of $9,565 (124 hr * $77.14/hr). We averaged this burden for the 62 plans over the 2021 and 2022 plan years, resulting in an annual burden of 62 hours (124 hr/2 yr) at a cost of $4,783 ($9,565/2 yr).

The vast majority of MA organizations with existing D–SNP look-alikes also have an MA–PD plan with a premium of $0 or a D–SNP in the same service area as the D–SNP look-alike. Consequently, we do not believe many MA organizations will choose to create a new D–SNP as a result of this final rule. The prevalence of existing MA–PD plans and D–SNPs also makes it unlikely that an MA organization will need to expand a service area for an existing MA–PD plan or D–SNP. Therefore, we do not expect this provision to have further impact beyond the currently burden approved under control number 0938–0935 (CMS–10237) for creating a new MA–PD plan or D–SNP and expanding a service area.

As finalized in § 422.514(e)(2)(ii), the MA organization will be required to describe changes to MA–PD plan benefits and provide information about the MA–PD plan into which the individual is enrolled in the Annual Notice of Change (ANOC) that the MA organization must send, consistent with § 422.111(a), (d), and (e). Consistent with § 422.111(d)(2), enrollees will receive this ANOC describing the change in plan enrollment and any differences in plan enrollment at least 15 days prior to the first day of the annual election period (AEP). As each MA plan must send out the ANOC to all enrollees annually, we do not estimate that MA organizations will incur additional burden for transitioned enrollees. The current burden for the ANOC is approved under control number 0938–1051 (CMS–10260).

Additionally, we do not expect any plans will be required to send affected enrollees a written notice consistent with the non-renewal notice requirements at § 422.506(a)(2) and described at § 422.514(e)(4), as we anticipate all MA organizations with D–SNP look-alikes will be able to transition their enrollees into another MA–PD plan (or plans). However, we are finalizing the requirement to ensure protection of enrollees if the situation does occur.

In subsequent years (2023 and beyond), we estimate that at most five plans per year will be identified as D–SNP look-alikes under § 422.514(d) due to meeting the enrollment threshold for dually eligible individuals or operating in a state that will begin contracting with D–SNPs or other integrated plans. We believe that these plans would non-renew and transition their membership into another MA–PD plan or a D–SNP. Therefore, the annual burden for the 2023 plan year and subsequent years is estimated at 10 hours (5 plans * 2 hr/plan) at a cost of $771 (10 hr * $77.14/hr) for a business operations specialist to transition enrollees into a new MA–PD plan.

The average annual burden for MA plans over three years is 45 hours ([62 hr + 62 hr + 10 hr]/3 yr) at a cost of $3,446 ([$4,783 + $4,783 +$771]/3 yr). The impact is summarized in Table 4.

b. MA Plan Enrollee Requirements and Burden

The following changes will be submitted to OMB for approval under control number 0938–NEW (CMS–10718). The control number for CMS–10718 has yet to be issued. The status of OMB's review/approval can be monitored at *https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202003-0938-002.*

Section 422.514(e)(2) allows any individual transitioned from a D–SNP look-alike to another MA–PD plan to stay in the MA–PD plan receiving the enrollment or make a different election. The enrollees may choose new forms of coverage for the following plan year, including a new MA–PD plan or receiving services through the original Medicare fee-for-service program option and enrollment in a stand-alone Prescription Drug Plan (PDP). Because the enrollment transition process will be effective on January 1 and notices would be provided during the AEP, affected individuals have opportunities to make different plan selections through the AEP (prior to January 1) or the Medicare Advantage Open Enrollment Period (after January 1). Affected individuals may also qualify for a Special Election Period (SEP), such as the SEP for plan non-renewals at § 422.62(b)(1) or the SEP for dually eligible/LIS beneficiaries at § 423.38(c)(4).

Based on our experience with passive enrollment of dually eligible beneficiaries into a new plan under the same parent organization for MMPs in the Financial Alignment Initiative, we estimate that one percent of the 180,758 transitioning D–SNP look-alike enrollees will select a new plan or the original Medicare fee-for-service program and PDP option rather than accepting the transition into a different MA–PD plan or D–SNP under the same MA organization as the D–SNP look-alike in which they are currently enrolled. We estimate that 1,808 enrollees (180,758 transitioning D–SNP look-alike enrollees * 0.01), will opt out of the new plan into which the D–SNP look-alike transitioned them. Consistent with the burden estimates under the aforementioned control number, the enrollment process requires 20 minutes (0.3333 hours) and remains unchanged. For this final rule, the total added burden for enrollees will be 603 hours (1,808 enrollees * 0.3333 hr/response) at a cost of $15,509 (603 hr * $25.72/hr). We are averaging this burden over the 2021 and 2022 plan years, resulting in an annual burden of 302 hours (603 hr/2 yr) at a cost of $7,755 ($15,509/2 yr).

As stated previously, we believe that in subsequent years (2023 and beyond), at most five plans will be identified as D–SNP look-alikes and therefore this final regulation would have a much smaller impact on MA enrollees after the initial period of implementation. Since the current 62 D–SNP look-alike plans have 180,758 enrollees in 62 plans, we estimate 14,577 enrollees (180,758 enrollees * 5/62 plans) in 5 plans. Therefore, the maximum number of enrollees affected per year is estimated to be 146 enrollees (14,577 total enrollees estimated in five plans * 0.01 who would select another plan). This would amount to a maximum annual burden of 49 hours (146 enrollees * 0.3333 hr) at a cost of $1,260 (49 hr * $25.72/hr).

The average annual enrollee burden over three years is therefore 218 hours ([302 hr + 302 hr + 49 hr]/3 yr) at a cost of $5,590 ([$7,755 + $7,755 + $1,260]/3yr). The estimates are summarized in Table 4.

c. Burden Summary

The burden for the provisions are summarized in Table 4.

TABLE 4—SUMMARY OF BURDEN ESTIMATES FOR CONTRACT REQUIREMENTS AT § 422.514

Respondents	Subject	OMB Control No. (CMS ID No.)	2021	2022	2023	3-year average
MA organization	Transition enrollees (§ 422.514(e)).	0938–0753 (CMS–R–267).	$4,783 (62 hr).	$4,783 (62 hr).	$771 (10 hr)	$3,446 (45 hr)
Beneficiaries	Enrollment request (§ 422.514(e)).	0938–NEW (CMS–10718)	$7,755 (302 hr).	$7,755 (302 hr).	$1,260 (49 hr).	$5,590 (218 hr)
Total			$12,538 (364 hr).	$12,538 (364 hr.	$2,031 (59 hr).	$9,036 (263 hr)

3. ICRs Regarding Medicare Advantage (MA) Plan Options for End-Stage Renal Disease (ESRD) Beneficiaries (§§ 422.50, 422.52, and 422.110)

As discussed in section III.A. of this final rule, we are revising §§ 422.50(a)(2), 422.52(c), and 422.110(b) to allow ESRD beneficiaries, without any limitation not otherwise applicable for enrollment in the MA program to enroll in an MA plan. In estimating the impact of this provision, we are required to separately estimate impact on beneficiaries and plans. Enrollment processing and notification requirements codified at § 422.60, are not being revised as part of this rulemaking, and no new or additional information collection requirements are being imposed.

Additionally, as explained in section VIII.D.1 of this final rule, OACT has already incorporated an increase in ESRD enrollment in the Medicare Trust Fund baseline due to the legislation. Therefore, there is no need to estimate plan burden. However, the burden to enrollees for completing enrollment forms has not been incorporated into the OACT baseline and therefore is estimated later in this section.

We did not receive any public comments on our proposed requirements. In the proposed rule, beneficiary burden was estimated using the ''long'' enrollment form that is currently approved by OMB under control number 0938–0753 (CMS–R–267). Based on internal review, in this final rule, the beneficiaries will instead, be completing a new, ''shortened'' form (OMB control number 0938–NEW (CMS–10718)) for enrollment into MA plans beginning with the 2020 AEP, for a January 1, 2021 effective date. The new ''shortened'' enrollment form, which is three pages in length, (compared to the current model form which is seven pages), limits the data collection to the minimum that is lawfully required to process the enrollment and other limited information that the sponsor is required to, or chooses to, provide to the beneficiary.

As indicated in the beginning of this section, the shortened form has been subject to the standard non-rule PRA process (see 84 FR 63655 (November 18, 2019), 84 FR 64319 (November 21, 2019), and 85 FR 13163 (March 6, 2020)) and is currently under OMB review.

In this final rule, we are correcting our proposed beneficiary burden estimates by considering the completion of the shortened enrollment form (CMS–10718) in lieu of (CMS–R–267). As indicated in section VII.A. of this final rule, we have also revised our proposed cost figures based on more recent BLS wage estimates.

To elect a MA plan, an individual must complete and sign an election form, complete another CMS-approved election method offered by the MA plan, or call 1–800–MEDICARE, and provide information required for enrollment. Regardless of the enrollment mechanism, similar identifying information is collected by the MA plan to process the enrollment.

Although not effective until January 1, 2021, section 17006 of the Cures Act amends the Act by allowing ESRD beneficiaries, without any limitation not otherwise applicable for enrollment in the MA program, to enroll in an MA plan. The burden is associated with the effort for an ESRD beneficiary seeking to enroll in a MA plan to complete an enrollment request. Because there will be an increase in the number of beneficiaries eligible to elect an MA plan starting in plan year 2021, the number of beneficiaries who are expected to initiate an enrollment action will increase. However, the erroneous per response time estimate of 30 minutes (0.5 hr) (CMS–R–267) that was set out in our proposed rule will decrease to 20 minutes (0.3333 hr) per response based on beneficiary completion of the new, shortened enrollment form (CMS–10718)).

As detailed in section VIII.D.1. of this final rule, OACT estimates an average increase of 59,000 ESRD beneficiaries to enroll in MA plans per year in 2021 through 2023. Therefore, we expect an average annual burden of 19,665 hours (59,000 new ESRD enrollees * 0.3333 hr) at a cost of $505,784 (19,665 hr * $25.72/hr).

4. ICRs Regarding Medical Loss Ratio (MLR) (§ 422.2440)

MSA Enrollment

The anticipated changes affecting MSA enrollment will be submitted to OMB for approval under control number 0938–0753 (CMS–R–267). Subject to renewal, the control number is currently set to expire on December 31, 2021. We did not receive any comments pertaining to our proposed requirements or burden estimates. However, based on internal review, we have updated our proposed time to complete the enrollment form and adjusted (increased) our enrollment figures to better reflect implementation in 2022–2024. As indicated above in section VII.A. of this final rule, we have also revised our proposed cost figures based on more recent BLS wage estimates.

As discussed in section IV.D.4. of this rule, we are finalizing our proposal to amend § 422.2440 to provide for the application of a deductible factor to the MLR calculation for MA MSA contracts that receive a credibility adjustment. The deductible factor would serve as a multiplier on the credibility factor. The application of the deductible factor would increase the MLRs of MSA contracts that receive this adjustment.

We believe that the change to the MLR calculation for MSAs could potentially cause the number of enrollees in MSA plans to increase relative to enrollment projections under the current regulations because we expect more MA organizations to offer MA MSA plans based on this change in the MLR calculation. Consistent with the proposed rule, for this impact estimate, we assume the following:

- Enrollment in MSAs will double over the first 3 years that the change is in effect. We believe 3 years is a reasonable time frame for the enrollment changes resulting from this policy to be phased in. We project that enrollment will double in order to avoid potentially understating the cost for the

proposal. Our estimate is based on the largest potential change in enrollment that we could reasonably anticipate. We acknowledge that the change could have no impact on enrollment.

- Relative to projections in the baseline, MSA enrollment will be 33.33 percent higher in contract year 2022 (increasing from 7,812 to 10,416), 66.67 percent higher in 2023 (increasing from 8,179 to 13,632), and 100 percent higher in contract year 2024 (increasing from 8,531 to 17,062) to contract year 2030 (increasing from 10,354 to 20,708).
- Half of the new enrollees in MA MSA plans would otherwise have been enrolled in other types of MA plans, and half would otherwise have been enrolled in FFS Medicare. We did not have a basis for assuming whether migration to MSAs would predominantly be from FFS Medicare or from non-MSA MA plans.

The process for enrolling in an MA plan is the same regardless of whether that plan is an MSA or a non-MSA. Therefore, we assume that the burden to enroll in an MSA plan and a non-MSA plan is the same. Therefore, the increased burden related to changes in MSA enrollment is attributable only to the portion of potential new MSA enrollees who would be expected to enroll in (or remain in) FFS Medicare if the proposal were not finalized. The cost burden of the provision is summarized in Table 5.

a. Beneficiary Requirements and Burden

For beneficiaries, the burden associated with the expected increase in MSA enrollment as a consequence of the addition of a deductible factor to the MSA MLR calculation is related to the effort it takes for a beneficiary to complete an enrollment request. It takes 0.5 hours at $25.72/hr for a beneficiary to complete an enrollment form. We assume no burden increase for the estimated 50 percent of additional MSA enrollees who would otherwise be enrolled in a non-MSA MA plan. For 2022, the burden for all beneficiaries is estimated at 434 hours (2,604/2 beneficiaries * 0.3333 hr) at a cost of $11,162 (651 hr * $25.72/hr). For 2023, the burden for all beneficiaries is estimated at 909 hours (5,453/2 beneficiaries * 0.3333 hr) at a cost of $23,379 (1,302 hr * $25.72/hr). For 2024, the burden for all beneficiaries is estimated at 1,422 hours (8,531/2 beneficiaries * 0.3333 hr) at a cost of $ $36,574 (1,422 hr * $25.72/hr).

The average burden per year is 922 hours ([434 + 909 + 1422]/3) at a cost of $23,705 ([11,162 + 23,379 + 36,574]/3).

b. MA Organization Estimate

There are currently four MA organizations offering MSA plans in 2020. We project that this number will double in 2022 as a result of the change. We therefore estimate that the change would result in approximately 2,604 total additional enrollments in MSAs in 2022, or 326 additional enrollments per organization (2,604 individuals/8 organizations); in 2023, 5,453 total additional enrollments in MSAs, or 682 additional enrollments per organization (5,453 individuals/8 organizations); and in 2024, and 8,531 total additional enrollments, or 1,066 additional enrollments per organization (8,531 individuals/8 organizations).

An MA organization must give a beneficiary prompt written notice of acceptance or denial of the enrollment request in a format specified by CMS that meets the requirements set forth in this section. The burden associated with each organization providing the beneficiary prompt written notice, performed by an automated system, is estimated at 1 minute per application processed. We estimate that it will take 1 minute at $77.14/hr for a business operations specialist to electronically generate and submit a notice to convey the enrollment or disenrollment decision for each beneficiary. As noted previously, we anticipate that half of the new enrollees in MSAs will already be enrolled in other MA plans, meaning the current burden estimate for their enrollment is already accounted for in the currently approved collection.

For 2022, the burden to complete the notices for the other half of new MSA enrollees (that is, the new enrollees who would otherwise enroll in FFS Medicare) is approximately 22 hours (2,604/2 notices * 1 min/60) at a cost of $1,697 (22 hr * $77.14/hr) or $1.30 per notice ($1,697/1,302 notices) or $212 per organization ($1,697/8 MA organizations). For 2023, the burden to complete the notices for the half of new MSA enrollees who would otherwise enroll in FFS Medicare is approximately 45 hours (5,453/2 notices * 1 min/60) at a cost of $3,471 (45 hr * $77.14/hr) or $1.28 per notice ($3,471/2,727 notices) or $434 per organization ($3,471/8 MA organizations). For 2024, the burden is approximately 71 hours (8,531/2 notices * 1 min/60) at a cost of $5,477 (71 hr * $77.14/hr) or $1. 1.34 per notice ($5,470/4,090 notices) or $685 per organization ($5,246/8 MA organizations).

The average burden per year is 46 hours ([22 hr + 45 hr + 71 hr]/3) at an average cost of $3,548 ([$1,697 + $3,471 + $5,477]/3).

The burden associated with electronic submission of enrollment information to CMS is estimated at 1 minute at $77.14/hr for a business operations specialist to submit the enrollment information to CMS during the open enrollment period. For 2022, the burden to complete the notices for the other half of new MSA enrollees (that is, the new enrollees who would otherwise enroll in FFS Medicare) is approximately 22 hours (2,604/2 notices * 1 min/60) at a cost of $1,697 (22 hr * $77.14/hr) or $1.30 per notice ($1,697/1,302 notices) or $212 per organization ($1,697/8 MA organizations). For 2023, the burden to complete the notices for the half of new MSA enrollees who would otherwise enroll in FFS Medicare is approximately 45 hours (5,453/2 notices * 1 min/60) at a cost of $3,471 (45 hr * $77.14/hr) or $1.28 per notice ($3,471/2,727 notices) or $434 per organization ($3,471/8 MA organizations). For 2024, the burden is approximately 71 hours (8,531/2 notices * 1 min/60) at a cost of $5,477 (71 hr * $77.14/hr) or $1.33 per notice ($5,477/4,090 notices) or $685 per organization ($5,477/8 MA organizations).

The average burden per year is 46 hours ([22 hr + 45 hr + 71 hr]/3) at an average cost of $3,548 ([$1,697 + $3,471 + $5,477]/3).

Additionally, MA organizations will have to retain a copy of the notice in the beneficiary's records. The burden associated with this task is estimated at 5 minutes at $36.82/hr for an office and administrative support worker to perform record retention for the additional MA MSA enrollees.

In aggregate, we estimate an annual burden for 2022 of 109 hours (2,604/2 beneficiaries * 5 min/60) at a cost of approximately $4,013 (109 hr * $36.82/hr) or $502 per organization ($4,013/8 MA organizations). For 2023, we estimate an aggregated annual burden of 227 hours (5,453/2 beneficiaries * 5 min/60) at a cost of approximately $8,358 (227 hr * $36.82/hr) or $1,634 per organization ($7,821/8 MA organizations). For 2024, we estimate an aggregated annual burden of 355 hours (8,531/2 beneficiaries * 5 min/60) at a cost of approximately $13,071 (355 hr * $36.82/hr) or $1,634 per organization ($13,071/8 MA organizations).

The average burden per year is 230 hours ([109 hr + 227 hr + 355 hr]/3) at an average cost of $8,481 ([$4,013 + $8,358 + $13,071]/3).

MLR Calculation

The changes affecting the MLR calculation will be submitted to OMB for approval under control number 0938–1232 (CMS–10476). Subject to

renewal, the control number is currently set to expire on December 31, 2021.

We did not receive any public comments on our proposed requirements or burden estimates. We are finalizing the requirements as proposed. We are also finalizing the burden estimates, with the following revisions: (1) We updated our cost figures using more recent BLS wage estimates; (2) we reduced the hour burden for an enrollee to fill out an enrollment form; and (3) we adjusted the 3-year phase-in period for the anticipated enrollment changes from 2021 to 2023 in the proposed rule to 2022 to 2024 in this final rule.

MA organizations will need to spend additional time calculating the MLRs for MSA contracts in order to apply the deductible factor. We estimate that for each of the 8 MA organizations that we anticipate will offer MSA contracts in 2022 and in each year through 2030, it will take an actuary approximately 5 minutes (0.0833 hr) at $116.32/hr to calculate the deductible factor for the contract. In aggregate, we estimate an annual burden of 0.6664 hours (0.0833 hr * 8 MA organizations) at a cost of $78 (0.6664 hr × $116.32/hr) or $10 per organization ($78/8 organizations).

For 2022, we estimate a total burden for all MA organizations resulting from this provision to be 154 hours (22 hr + 22 hr + 109 hr + 0.6664 hr) at a cost of $7,485 ($1,697 + $1,697 + $4,013 + $78). Per organization, we estimate an annual burden of 19.3 hours (154 hr/8 MA organizations) at a cost of $935.63 ($7,485/8 organizations).

For 2022, we estimate a total burden for all MA organizations resulting from this provision to be 154 hours (22 hr + 22 hr + 109 hr + 0.6664 hr) at a cost of $7,485 ($1,697 + $1,697 + $4,013 + $78). Per organization, we estimate an annual burden of 19.3 hours (154 hr/8 MA organizations) at a cost of $935.63 ($7,485/8 organizations).

For 2023, we estimate a total burden for all MA organizations resulting from this provision to be 318 hours (45 hr + 45 hr + 227 hr + 0.6664 hr) at a cost of $15,378 ($3,471 + $3,471 + $8,358 + $78). Per organization, we estimate an annual burden of approximately 40 hours (318 hr/8 MA organizations) at a cost of $1,922.50 ($15,378/8 organizations).

For 2024, we estimate a total burden for all MA organizations resulting from this provision to be 498 hours (71 hr + 71 hr + 355 hr + 0.6664 hr) at a cost of $24,103 ($5,477 + $5,477 + $13,071 + $78). Per organization, we estimate an annual burden of approximately 62 hours (498 hr/8 MA organizations) at a cost of $3,013 ($24,103/8 organizations).

The burden for beneficiaries is a single burden for each year and has been estimated above.

d. Summary

The figures in Table 5 associated with beneficiaries' enrollment requests, MA organizations providing beneficiaries with notice of acceptance or denial of the enrollment request, MA organizations' submission of enrollment information to CMS, and MA organizations' retention of a copy of the notice in beneficiaries' records will be submitted to OMB for approval under control number 0938–0753 (CMS–R–267). The figures associated with the calculation of the deductible factor for MA MSA contracts will be submitted to OMB for approval under control number 0938–1232 (CMS–10476).

TABLE 5—IMPACT OF MSA/MLR BY SUBJECT

Respondents	Subject	OMB Control No. (CMS ID No.)	2022	2023	2024	Average
Beneficiaries	Enrollment request (§ 422.2440)	0938–0753 (CMS–R–267)	$11,162 (434 hr)	$23,379 (909 hr)	$36,574 (1,422 hr)	$23,705 (922 hr)
MA organizations	Notice to beneficiaries (§ 422.2440)	0938–0753 (CMS–R–267)	$1,697 (22 hr)	$3,471 (45 hr)	$5,477 (71 hr)	$3,548 (46 hr)
MA organizations	Submission to CMS (§ 422.2440)	0938–0753 (CMS–R–267)	$1,697 (22 hr)	$3,471 (45 hr)	$5,477 (71 hours)	$3,548 (46 hrs)
MA organizations	Record retention (§ 422.2440)	0938–0753 (CMS–R–267)	$4,013 (109 hr)	$8,358 (227 hr)	$13,071 (355 hr)	$8,481 (230 hr)
MA organizations	Calculation of deductible factor. (§ 422.2440)	0938–1232 (CMS–10476)	$78 (0.6664 hr)	$78 (0.6664 hr)	$78 (0.6664 hr)	$78 (0.6664 hr)
Total			$7,485 (154 hr)	$15,378 (318 hr)	$24,103 (498 hr)	$15,655 (322 hr)

5. ICRs Regarding Special Election Periods (SEPs) for Exceptional Conditions (§§ 422.62 and 423.38)

The following changes will be submitted to OMB for approval under control number 0938–0753 (CMS–R–267) for Part C and 0938–0964 (CMS–10141) for Part D.

As discussed in section V.B. of this final rule, we are finalizing all SEPs as proposed, with the exception of the SEP for Government Entity—Declared Disaster or Other Emergency at §§ 422.68(b)(18) and 423.38(c)(23), which we are finalizing, with modification. We are also codifying the SEP for Individuals Involuntarily Disenrolled from an MA–PD plan due to loss of Part B, which was inadvertently omitted from the proposed rule.

We did not receive any comments on our proposed requirements and are finalizing them without change. As indicated in section VII.A. of this final rule, we have revised our proposed cost figures based on more recent BLS wage estimates. We are not making any changes to our proposed time estimates.

We are codifying certain Part C (at § 422.62(b)(4) through (25)) and Part D (at § 423.38(c)(11) through (32)) SEPs for exceptional circumstances currently set out in sub-regulatory guidance that MA organizations and Part D plan sponsors have implemented and are currently following. We are also establishing two new additional SEPs for exceptional circumstances: The SEP for Individuals Enrolled in a Plan Placed in Receivership and the SEP for Individuals Enrolled in a Plan that has been identified by CMS as a Consistent Poor Performer.

We do not believe the changes will adversely impact individuals requesting enrollment in Medicare health or drug plans, the plans themselves, or their current enrollees. Similarly, we do not believe the changes would have any impact on the Medicare Trust Fund.

MA organizations and Part D plan sponsors are currently assessing applicants' eligibility for election

periods as part of existing enrollment processes; therefore, no additional burden is anticipated from this change. However, because the burden for determining an applicant's eligibility for an election period has not previously been submitted to OMB, due to inadvertent oversight, we are seeking their approval under the aforementioned OMB control numbers.

The following changes will be submitted to OMB for approval under control number 0938–0753 (CMS–R–267). We estimate it would take 5 minutes (0.0833 hr) at $77.14/hr for a business operations specialist to determine an applicant's eligibility for an election period.

The burden for all MA organizations is estimated at 142,497 hours (1,710,650 beneficiary SEP elections * 0.0833 hr) at a cost of $10,992,219 (142,497 hr * $77.14/hr) or $60,731 per parent organization ($10,992,219/181 MA parent organizations).

The following changes will be submitted to OMB for approval under control number 0938–0964 (CMS–10141). The burden for all Part D parent organizations is estimated at 155,564 hours (1,867,519 beneficiary SEP elections * 0.0833 hr) at a cost of $12,000,207 (155,564 hr * $77.14/hr) or $226,419 per Part D parent organization ($12,000,207/53 Part D parent organizations).

As discussed in section V.B. of this final rule, we are finalizing all SEPs as proposed, with the exception of the SEP for Government Entity—Declared Disaster or Other Emergency at §§ 422.68(b)(18) and 423.38(c)(23). We are also codifying the SEP for Individuals Involuntarily Disenrolled from an MA–PD plan due to loss of Part B, which was inadvertently omitted from the proposed rule.

C. Summary of Information Collection Requirements and Associated Burden Estimate

TABLE 6—ANNUAL INFORMATION COLLECTION REQUIREMENTS

Provision	Regulatory citation	OMB Control No.	Respondent type	Response summary	Total number of respondents	Total number of responses	Time per response (hr)	Total annual time (hr)	Labor cost ($/hr)	Total annual cost ($)
D–SNP Look-Alikes.	§ 422.514(e)	0938–NEW.	Enrollees	D–SNP Look-Alikes: Enrollment.	1,954	1,954	0.3333	218	25.72	5,590
ESRD	§§ 422.50 and 422.52.	0938–NEW.	Enrollees	ESRD: Enrollment.	59,000	59,000	0.3333	19,665	25.72	505,784
MSA MLR	§§ 422.2420, 422.2440, and 422.2430.	0938–0753.	Enrollees	MSA MLR: Filling out enrollment forms.	16,588	16,588	0.3333	922	25.72	23,705
	Subtotal Enrollees.	Varies ..	Enrollees	Varies	77,542	77,542	Varies	20,805	Varies	535,079
SSCBI	422.102(f)(3)(i)	0938–0763.	MA Plans	SSBCI: Criteria (initial software update).	234	1	12	2,808	103.33	96,717
SSCBI	422.102(f)(3)(i)	0938–0763.	MA Plans	SSBCI: Criteria (Annual physician review).	234	1	36	8,424	193.7	1,631,729
SSCBI	422.102(f)(3)(i)	0938–0763.	MA Plans	SSBCI: Criteria (Software updates).	234	1	5	1,170	85.26	99,754
SSCBI	422.102(f)(3)(ii)	0938–0763.	MA Plans	SSBCI: Documentation.	234	1	2	468	56.34	26,367
SSCBI	422.102(f)(3)(iii)	0938–0763.	MA Plans	SSBCI: Enrollee records.	234	1	9	702	86.95	61,039
D–SNP Look-Alikes.	§ 422.514 (e) ...	0938–0753.	MA Plans	D–SNP Look-Alikes: Transition.	67	67	2	45	77.14	3,446
MSA MLR	§§ 422.2420, 422.2440, and 422.2430.	0938–0753.	MA Plans	MSA MLR: Notify enrollees.	8	8	0.0167	46	77.14	3,548
MSA MLR	§§ 422.2420, 422.2440, and 422.2430.	0938–0753.	MA Plans	MSA MLR: Submit to CMS.	8	8	0.0167	46	77.14	3,548
MSA MLR	§§ 422.2420, 422.2440, and 422.2430.	0938–0753.	MA Plans	MSA MLR: Archive.	8	8	0.0833	230	36.82	8,481
MSA MLR	§§ 422.2420, 422.2440, and 422.2430.	0938–1252.	MA Plans	MSA MLR: Calculation of the deductible factor.	8	8	0.0833	0.6664	116.32	78
Part C Election Period.	§ 422.62	0938–0753.	MA Plans	Part C Election Period: Determine eligibility.	181	1,710,650	0.0833	142,497	77.14	10,992,219

Back to Agenda Back to Item

TABLE 6—ANNUAL INFORMATION COLLECTION REQUIREMENTS—Continued

Provision	Regulatory citation	OMB Control No.	Respondent type	Response summary	Total number of respondents	Total number of responses	Time per response (hr)	Total annual time (hr)	Labor cost ($/hr)	Total annual cost ($)
Part D Election Period.	§ 422.38	0938–0964.	Part D Plans.	Part D Election Period: Determine eligibility.	53	1,867,519	0.0833	155,564	77.14	12,000,207
	Subtotal MA Plans.	Varies ..	MA Plans	Varies	309	Varies	Varies	312,001	Varies	24,927,133
	Grand Total All	Varies ..	Varies	Varies	77,851	.....	.....	332,806	.....	25,462,212

VIII. Regulatory Impact Analysis

A. Statement of Need

This final rule implements a subset of the proposals from the proposed rule. We took a measured approach to review each provision proposed and focused finalizing in this first final rule those most helpful for bidding, those that address the COVID–19 pandemic and public health emergency, as well as those topics on which issuing a final rule now would advance the MA program.

Summaries of the public comments that are within the scope of the provisions' proposed regulatory impact analyses implemented in this final rule are included in this section with our responses under the appropriate headings. The provisions in this final rule implement specific provisions of the BBA of 2018 and the 21st Century Cures Act. The statutory need for these policies is clear. However, this rule also contains discretionary policies, hence we provide economic justification in the following paragraphs.

We estimate that the proposed Star Ratings provisions would result in an overall net savings for the Medicare Trust Fund. There are two changes that may impact a contract's Star Rating: (1) We proposed to increase measure weights for patient experience/complaints and access measures from two to four to further emphasize the patient voice, and (2) we proposed the use of Tukey outlier deletion, which is a standard statistical methodology for removing outliers, to increase the stability and predictability of the non-CAHPS measure cut points. The increased weight reflects CMS's commitment to put patients first and to empower patients to work with their doctors to make health care decisions that are best for them. Since more outliers tend to be at the low end of the distribution (worse performers), directly removing outliers causes some shifting downward in overall Star Ratings. The increased measure weights for patient experience/complaints and access revision is assumed to be a cost to the Medicare Trust Fund given the ratings for these measures tend to be higher relative to other measures, and the Tukey outlier deletion is assumed to be a saver to the Medicare Trust Fund after the first year since directly removing outliers results in a shift downward in ratings. The aggregate savings to the Medicare Trust Fund over 2024–2030 is $4.1 billion.

B. Overall Impact

We examined the impact of this final rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), Executive Order 13272 on Proper Consideration of Small Entities in Agency Rulemaking (August 13, 2002), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017). This rule, under Executive Order 12866, is economically significant with over $100 million in costs, benefits, or transfers annually. Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), the Office of Information and Regulatory Affairs designated this rule as a major rule as defined by 5 U.S.C. 804(2).

A regulatory impact analysis must be made for major rules with economically significant effects ($100 million or more in any one year). We estimate that this final rule is economically significant as measured by the $100 million threshold and hence, it is also a major rule under the Congressional Review Act. Accordingly, we have prepared a regulatory impact analysis that to the best of our ability presents the costs and benefits of this rulemaking.

Section 202 of UMRA also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2020, that threshold is approximately $156 million. This final rule is not anticipated to have an unfunded effect on state, local, or tribal governments, in the aggregate, or on the private sector of $154 million or more.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. Since this final rule does not impose any substantial costs on state or local governments, preempt state law or have federalism implications, the requirements of Executive Order 13132 are not applicable.

If regulations impose administrative costs on reviewers, such as the time needed to read and interpret this final rule, then we should estimate the cost associated with regulatory review. There are currently 795 contracts (which includes MA, MA–PD, and PDP contracts), 55 state Medicaid agencies, and 300 Medicaid MCOs. We also expect a variety of other organizations to review (for example, consumer advocacy groups, major Pharmacy Benefit Managers). We expect that each organization will designate one person to review the rule. A reasonable maximal number is 2,000 total reviewers. We note that other assumptions are possible.

Using the BLS wage information for medical and health service managers (code 11–9111), we estimate that the cost of reviewing this final rule is $110.74 per hour, including fringe benefits and overhead costs (*http://www.bls.gov/oes/current/oes_nat.htm*). Assuming an average reading speed, we estimate that it will take approximately 100 hours for each person to review this final rule. For each entity that reviews the rule, the estimated cost is therefore $11,074 (100 hours * $110.74). Therefore, we estimate that the

maximum total cost of reviewing this final rule is $22 million ($11,074 * 2,000 reviewers). We expect that many reviewers will not review the entire rule but just the sections that are relevant to them. If each person on average reviews 10 percent of the rule, then the cost would be $2.2 million.

Note that this analysis assumed one reader per contract. Some alternatives include assuming one reader per parent organization. Using parent organizations instead of contracts will reduce the number of reviewers. However, we believe it is likely that review will be performed by contract. The argument for this is that a parent organization might have local reviewers assessing potential region-specific effects from this final rule.

In accordance with the provisions of Executive Order 12866, this rule was reviewed by OMB.

C. Impact on Small Businesses—Regulatory Flexibility Analysis (RFA)

The RFA, as amended, requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions.

This final rule has several provisions. Although some provisions are technical or codify existing guidance, and therefore are not expected to have economic impact beyond current operating expenses, there are other provisions with paperwork or other costs. These provisions are analyzed in both this section and in section VII of this final rule. A compact summary of burdens by year and provision are summarized in Tables 6 and 16 of this final rule.

This rule has several affected stakeholders. They include (1) insurance companies, including the five types of Medicare health plans, MA organizations, PDPs, cost plans, Medical Savings Account plans (MSA), PACE organizations, and demonstration projects, (2) providers, including institutional providers, outpatient providers, clinical laboratories, and pharmacies, and (3) enrollees.

Some descriptive data on these stakeholders are as follows:

- Pharmacies and Drug Stores, NAICS 446110, have a $30 million threshold for ''small size'' with 88 percent of pharmacies, those with less than 20 employees, considered small.
- Direct Health and Medical Insurance Carriers, NAICS 524114, have a $41.5 million threshold for ''small size,'' with 75 percent of insurers having under 500 employees meeting the definition of small business.
- Ambulatory Health Care Services, NAICS 621, including about 2 dozen sub-specialties, including Physician Offices, Dentists, Optometrists, Dialysis Centers, Medical Laboratories, Diagnostic Imaging Centers, have a threshold ranging from $8 to $35 million (Dialysis Centers, NAICD 621492, have a $41.5 million threshold). Almost all firms are big, and this also applies to sub-specialties. For example, for Physician Offices, NAICS 621111, receipts for offices with under 9 employees exceed $34 million.
- Hospitals, NAICS 622, including General Medical and Surgical Hospitals, Psychiatric and Substance Abuse Hospitals, and Specialty Hospitals have a $41.5 million threshold for small size, with half of the hospitals (those with between 20–500 employees) considered small.
- Skilled Nursing Facilities (SNFs), NAICS 623110, have a $30 million threshold for small size, with half of the SNFs (those with under 100 employees) considered small.

We are certifying that this final rule does not have a significant economic impact on a substantial number of small entities. To defend our position, we first describe at a high level the cash flows related to the Medicare program. We then provide more specific details.

The high-level underlying idea in creating the MA, Medicare Cost-plan, and MA–PD Medicare health insurance programs, is to allow private insurers to coordinate care, resulting in efficiencies of cost. The high-level underlying idea in creating the non-government-managed Prescription Drug program (PDPs and drug portion of MA–PDs) is to allow beneficiaries to obtain prescription drugs in a competitive market to reduce costs. For MA, MA–PD and Cost plans, enrollees obtain the same Original Medicare Part A and Part B services they would otherwise obtain in the original Medicare program, albeit at reduced cost (however, for the small percentage of plans bidding above the benchmark, enrollees pay more, but this percentage of plans is not ''significant'' as defined by the RFA and as justified below).

The savings achieved by the MA and the MA–PD plans, the amount of reduced cost, can then be used by the private insurers in a variety of ways, including providing benefits supplemental to original Medicare. Some examples of these supplemental benefits include vision, dental, and hearing. The cost for furnishing these supplemental benefits comes from a combination of the Trust Fund and enrollee premiums.

Part D plans submit bids and are paid by the Medicare Trust Fund for their projected costs in the form of direct premium subsidy and reinsurance. For any enrolled low-income beneficiaries, they receive low-income premium subsidy and low-income cost-sharing subsidy in addition. The national average monthly bid amount, or NAMBA, determines the base premium. A plan's premium is the sum of the base premium and the difference between its bid amount and the NAMBA.

Thus the cost of providing services by these insurers is met by a variety of government funding and in some cases by enrollee premiums.

In order to achieve these goals, the government pays the MA health plans a portion of the funds that would have been paid had plan enrollees remained in original Medicare. These funds are then used to provide additional benefits on behalf of the health plans' enrollees. Thus, by the initial design of the Medicare health plan programs, the various insurance programs were not expected to suffer burden or losses since, in this very unique insurance relationship, the private companies are being supported by the government who, in turn, is saving money because health plans, by virtue of coordinating care, are furnishing the same services, albeit at reduced cost. This lack of expected burden applies to both large and small health plans.

The unique MA regulations, such as those in this final rule, are defined so that small entities are not expected to incur additional burden since the cost of complying with any final rule is passed on to the government.

We next examine in detail each of the stakeholders and explain how they can bear cost. (1) For Pharmacies and Drug Stores, NAICS 446110; (2) for Ambulatory Health Care Services, NAICS 621, including about two dozen sub-specialties, including Physician Offices, Dentists, Optometrists, Dialysis Centers, Medical Laboratories, Diagnostic Imaging Centers, and Dialysis Centers, NAICD 621492; (3) for Hospitals, NAICS 622, including General Medical and Surgical Hospitals, Psychiatric and Substance Abuse Hospitals, and Specialty Hospitals; and (4) for SNFs, NAICS 623110: Each of these are providers (inpatient, outpatient, or pharmacy) that furnish plan-covered services to plan enrollees. Whether these providers are contracted or, in the case of PPOs, PFFS, and MSA, non-contracted with the MA plan, their aggregate payment for services is the sum of the enrollee cost sharing and

plan payments. For non-contracted providers, § 422.214 requires that a non-contracted provider accept payment that is least what they would have been paid had the services been furnished in a fee-for-service setting. For contracted providers, § 422.520 requires that the payment is governed by a contract which the provider and plan mutually agree to. Consequently, for these providers, there is no additional cost burden above the already existing burden in original Medicare.

For Direct Health and Medical Insurance Carriers, NAICS 524114, plans estimate their costs for the coming year and submit bids and proposed plan benefit packages. Upon approval, the plan commits to providing the proposed benefits, and CMS commits to paying the plan either (1) the full amount of the bid, if the bid is below the benchmark, which is a ceiling on bid payments annually calculated from original Medicare data; or (2) the benchmark, if the bid amount is greater than the benchmark.

Theoretically, there is additional burden if plans bid above the benchmark. However, consistent with the RFA, the number of these plans is not substantial. Historically, only two percent of plans bid above the benchmark, and they contain roughly one percent of all plan enrollees. Since the CMS criteria for a substantial number of small entities is 3 to 5 percent, the number of plans bidding above the benchmark is not substantial.

The preceding analysis shows that meeting the direct cost of this final rule does not have a significant economic impact on a substantial number of small entities, as required by the RFA.

There are certain indirect consequences of these provisions which also create impact. We have already explained that 98 percent of the plans bid below the benchmark. Thus, their estimated costs for the coming year are fully paid by the government. However, the government additionally pays the plan a ''beneficiary rebate'' amount that is an amount equal to a percentage (between 50 and 70 percent depending on a plan's quality rating) multiplied by the amount by which the benchmark exceeds the bid. The rebate is used to provide additional benefits to enrollees in the form of reduced cost sharing, lower Part B or Part D premiums, or supplemental benefits. (Supplemental benefits may also partially be paid by enrollee premiums if the plan choses to use premiums.) It would follow that if the provisions of this final rule cause the bid to increase and if the benchmark remains unchanged or increases by less than the bid does, the result would be a reduced rebate and possibly fewer supplemental benefits for the health plans' enrollees.

However, supplemental benefits are only one approach to using the rebate. The experience of OACT at CMS is that from year to year plans prefer to reduce their administrative costs, including profit margins, rather than substantially change their benefit package. This is true due to marketing forces; a plan lowering supplemental benefits even one year may lose its enrollees to competing plans that offer these supplemental benefits. Thus, it is advantageous to the plan to temporarily reduce administrative costs, including margins, rather than reduce benefits.

We note that we do not have definitive data on this. That is, we can at most note the way administrative costs and supplemental benefits vary from year to year. The thought processes behind the plan are not reported. More specifically, when supplemental benefits are reduced, we have no way of knowing the cause for this reduction, whether it be new provisions, market forces, or other causes.[54]

Based on the above, we certify that this final rule does not have a significant economic impact on a substantial number of small entities.

Finally, we note that this rule has an impact on enrollees. While enrollees as a group do not constitute a ''small business'' as defined by the RFA, and hence the impact of this final rule on enrollees is not discussed in this section, throughout this final rule we have carefully noted the impact on enrollees. One major impact on enrollees as presented in section VII of this final rule is the estimated half hour burden at a cost of $13 per enrollee for filling out enrollment forms. While the aggregate amount for all enrollees is several million, the per enrollee burden is not significant.

D. Anticipated Effects

Some provisions of this final rule have negligible impact either because they are technical provisions or are provisions that codify existing guidance. Other provisions have an impact although it cannot be quantified or whose estimated impact is zero. Throughout the preamble, we have noted when provisions have no impact. Additionally, this Regulatory Impact Analysis discusses several provisions with either zero impact or impact that cannot be quantified. The remaining provisions are estimated in section VII of this final rule and in this Regulatory Impact Analysis. Where appropriate, when a group of provisions have both paperwork and non-paperwork impact, this Regulatory Impact Analysis cross-references impacts from section VII of this final rule in order to arrive at total impact. Additionally, this Regulatory Impact Analysis provides pre-statutory impact of several provisions whose additional current impact is zero because their impact has already been experienced as a direct result of the statute. For further discussion of what is estimated in this Regulatory Impact Analysis, see Table 16 and the discussion afterwards.

1. Medicare Advantage (MA) Plan Options for End-Stage Renal Disease (ESRD) Beneficiaries (§§ 422.50, 422.52, and 422.110)

We are codifying requirements under section 17006 of the Cures Act that, effective for the plan year beginning January 1, 2021, would remove the prohibition on beneficiaries with ESRD enrolling in an MA plan. Since we are codifying existing statute, there is no impact to program expenditures. In order to estimate the impact of requirements under section 17006 of the Cures Act, a pre-statute baseline was used to estimate the impacts.

There are two primary assumptions that contribute to the regulatory impact analysis for this provision: (1) The increased number of beneficiaries with ESRD who choose to enroll in an MA health plan; and (2) the cost differential between MA and FFS for those enrollees with ESRD.

We are expecting that there will be an influx of beneficiaries switching from FFS to MA beginning on January 1, 2021 due to the provision. In 2019, there were 532,000 enrollees in ESRD status with Medicare Part A benefits as shown in the Medicare Enrollment Projections tables of the 2020 Rate Announcement. Of these, 401,000 enrollees were in the FFS program, which results in 131,000 in Private Health Plans. This equates to a private health penetration rate of about 25 percent. Absent the ESRD enrollment provision of the Cures Act, we project that ESRD enrollment in Private Health plans will grow to 144,000 in 2021, representing about 26 percent of the projected 2021 total ESRD population of 559,000. Based on an analysis by OACT, ESRD enrollment in MA plans is expected to increase by 83,000 due to the Cures Act provision. This increase is assumed to be phased in over 6 years, with half of the beneficiaries (41,500) enrolling during 2021.

Next, we determine the cost differential of the projected ESRD

[54] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3893317/.*

enrollees that are new to MA in 2021 due to the Cures Act. The cost differential between MA and FFS ESRD enrollees is attributed to the adjustment to MA risk scores for differences in diagnosis coding between MA and FFS beneficiaries. The Coding Intensity (Annual) was derived by examining historical risk score data and computing the differences between MA and FFS risk scores. Demographic differences (age, gender factors) for enrollees have been separated and removed from risk score comparisons so that the final differences are considered health status differences.

Table 7 shows the cost for codifying section 17006 of the Cures Act, removing the prohibition for ESRD beneficiaries to enroll in MA plans. The United States Per Capita Cost (USPCC) amounts for Part A and Part B can be found in the 2020 Rate Announcement. The Gross Costs (before backing out the Part B premium portion) is calculated by multiplying the Additional MA ESRD Enrollment by the ESRD–USPCC rates, which are on a per member per month basis, multiplied by 12 (the number of months in a year) multiplied by the Composite Coding Intensity. The Net Cost is calculated by multiplying the Gross Costs by the Net of Part B Premium amount which averages between 85.6% and 84.9% from 2021–2030. The Net Costs range from $23 million in contract year 2021 to $440 million in contract year 2030.

TABLE 7—ESTIMATED COST PER YEAR (MILLIONS) TO THE MEDICARE TRUST FUND FOR REMOVING THE PROHIBITION FOR ESRD BENEFICIARIES TO ENROLL IN MA PLANS

Contract year	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Additional MA ESRD Enrollment:	41,500	62,250	73,317	78,850	81,617	83,000	83,000	83,000	83,000	83,000
USPCC Pt A FFS ($):	3,206	3,328	3,447	3,562	3,681	3,801	3,924	4,052	4,184	4,320
USPCC Pt B FFS ($):	4,900	5,109	5,329	5,573	6,383	6,662	6,953	7,257	7,574	7,905
USPCC FFS ($):	8,106	8,437	8,776	9,136	10,063	10,462	10,877	11,309	11,758	12,225
Coding Intensity (Annual) (%):	0.65	0.80	0.79	0.63	0.46	0.30	0.14	0.14	0.13	0.13
Coding Intensity (Composite) (%):	0.65	1.46	2.26	2.90	3.38	3.69	3.84	3.98	4.12	4.25
Gross Cost ($ millions):	26	92	174	251	333	384	416	448	482	518
Net of Part B Premium (%):	85.60	85.60	85.50	85.40	85.30	85.20	85.00	84.90	84.90	84.90
Net Cost ($ millions):	23	79	149	214	284	327	353	381	410	440

Because these increases are already included in the baseline, they are not included in Table 15, nor do they contribute to the monetized table calculations (Table 15). However, notes to Table 15 and observations in the conclusion do mention this impact.

Comment: A commenter thanked CMS for sharing its projection of the magnitude of ESRD migration from Original Medicare to Medicare Advantage in 2021 and in future years; however, the commenter expressed several concerns with the methods and assumptions used. For example, the commenter requested CMS (i) produce a range of impacts, (ii) produce an alternative methodology based on adjustment to MOOP limits, and (iii–iv) reconsider certain assumptions about MLR and migration patterns. The commenter also asked if CMS, in considering migration patterns, took note that many ESRD retirees are already in EGWPs or that migration to MA plans will likely be higher in the under-65 ESRD population due to the lack of alternatives.

Response: A range of impacts for the estimated costs to the Medicare Trust Funds for removing the prohibition for ESRD beneficiaries to enroll in MA plans is described in section VIII.E.1. of this final rule.

CMS does not have the information readily available to produce an alternative adjustment to MOOPs; the proposal related to the MOOP limits for MA plans will be addressed in a future final rule. The cost to the plan sponsor of having a MOOP is captured as a supplemental benefit in the bid pricing. The plan sponsor bid pricing models and methodologies are proprietary health plan information and are not readily available to CMS. Furthermore, the MOOP for 2021 applies to all MA enrollees (ESRD and non-ESRD) and we do not believe it is reasonable to project alternative ESRD enrollment projections based on a MOOP that applies to all MA enrollees.

We did consider the migration patterns for EGWP ESRD beneficiaries versus Individual ESRD beneficiaries. We surmised that the costs differences between EGWP and Individual ESRD coverages are not significant enough to display the migration patterns separately. Displaying projections at that coverage level would not provide further understanding of the financial projections since the cost differences are not too different.

We did consider the migration patterns for younger versus older ESRD beneficiaries. In response to the commenter on page G24, we noted that the higher average age of the MA ESRD enrollee versus the lower average age of the FFS ESRD enrollee is a main reason that there are fewer kidney transplants in the MA population. Our expectation is that younger ESRD beneficiaries will begin to enroll in MA starting in 2021 and that the kidney transplant incidence rate for the two programs will begin to merge.

After review and consideration of the comments, we are finalizing this provision without modification.

2. Medicare Fee-for-Service (FFS) Coverage of Costs for Kidney Acquisitions for Medicare Advantage (MA) Beneficiaries (§ 422.322) and Exclusion of Kidney Acquisition Costs From Medicare Advantage (MA) Benchmarks (§§ 422.258 and 422.306)

Section 17006(b) of the Cures Act amended section 1853(k) and (n) of the Act to exclude standardized costs for kidney acquisitions from MA benchmarks starting in 2021. As such, we will codify these requirements so that, effective for the contract year beginning January 1, 2021, MA

organizations will no longer be responsible for costs for organ acquisitions for kidney transplants for their beneficiaries. Removing these costs from the MA benchmarks will decrease the amounts paid to the plans from the Medicare trust funds. Instead, as required by statute, Medicare FFS will cover the kidney acquisition costs for MA beneficiaries, effective 2021.

Since the budget baseline has reflected this change from the Cures Act, there is no additional impact of the proposed codification of this change to the computation of rates. To estimate the impact of the statute when published we used a pre-statute baseline. This impact of the statute will therefore not be included in Table 15 or Table 14, which deal with impacts of current provision.

Our analysis in the next section shows that: (1) FFS coverage of kidney acquisition costs for MA beneficiaries results in net costs to the Medicare Trust Funds ranging from $212 million in 2021 to $981 million in 2030; (2) Excluding kidney acquisition costs from MA benchmarks results in net savings estimated to range from $594 million in 2021 to $1,346 million in 2030. In addition, we anticipate no change in plan, provider, or beneficiary burden for these provisions. Plan burden would not be impacted by the change in their payment rate. Provider burden will not be impacted because they continue to bill for kidney acquisition regardless of whether they receive payment from FFS Medicare or MA organizations. Finally, beneficiaries would not be impacted by the change in the source of payment for the acquisition of the organ.

Next, we describe the steps used to calculate the savings associated with excluding kidney acquisition costs from MA benchmarks as well as the costs associated with requiring FFS coverage of kidney acquisition costs for MA beneficiaries.

First, we examined the FFS cost of kidney acquisition coverage. We calculate the expected costs to the FFS program for covering kidney acquisitions from the MA population starting in 2021. The costs for these services are expected to be lower than the amount that is expected to be excluded from the MA benchmarks for two reasons.

- The MA penetration rate for ESRD enrollees is lower than for the non-ESRD enrollees. This means that a higher percentage of beneficiaries with ESRD are in FFS than in MA, so there will likely be fewer kidney transplants in MA versus FFS. However, this enrollment difference will likely lessen as ESRD enrollees are permitted to enroll in MA plans beginning in 2021.
- The kidney transplant incidence rate for MA ESRD enrollees has historically been much lower than the kidney transplant incidence rate for FFS ESRD enrollees. We suspect that this is due to MA ESRD enrollees being in dialysis status for a shorter duration than FFS enrollees. Again, we believe that this difference (between MA and FFS) in the kidney transplant incidence rate will decrease over time as more ESRD beneficiaries enroll in MA plans.

The kidney transplant incidence rate is computed by dividing the number of kidney transplants by the ESRD enrollment separately for the MA and FFS programs. As shown in Table 8, the FFS kidney transplant incidence rate has historically often been more than three times the MA rate.

TABLE 8—MEDICARE FFS AND MA KIDNEY TRANSPLANTS (2013–2017)

	2013	2014	2015	2016	2017
Number of Kidney Transplants FFS:	13,964	13,866	14,400	15,191	15,346
ESRD Enrollment FFS (000's):	385	390	394	401	402
Transplant Incidence FFS (%):	3.6	3.6	3.7	3.8	3.8
Number of Kidney Transplants MA:	929	1,015	957	1,137	1,382
ESRD Enrollment MA (000's):	69	78	89	96	108
Transplant Incidence MA (%):	1.3	1.3	1.1	1.2	1.3

As mentioned, we expect that as a greater portion of enrollees with ESRD will join MA plans, starting in 2021, the difference in the kidney transplant incidence rate between MA and FFS will begin to lessen, as shown in Table 9. The total number of MA and FFS kidney transplants are expected to grow by 3 percent per year which is based on the 2013–2017 historical growth rate. That rate is higher than the average increase in MA and FFS ESRD enrollment of 2 percent for 2013–2017. Since the kidney transplant growth is projected to be higher than the ESRD enrollment growth, we expect the kidney transplant incidence rate to increase over time.

TABLE 9—MEDICARE FFS AND MA KIDNEY TRANSPLANTS (2018–2030)

	2018	2019	2020	2021	2022	2023	2024
Number of Kidney Transplants MA & FFS:	17,230	17,747	18,279	18,828	19,392	19,974	20,573
Kidney Transplant Incidence FFS (%):	3.9	4.0	4.0	4.2	4.3	4.4	4.3
Kidney Transplant Incidence MA (%):	1.4	1.4	1.4	1.6	1.8	2.0	2.2
ESRD Enrollment FFS (000's):	401	401	408	373	358	353	352
ESRD Enrollment MA (000's):	120	131	137	186	213	231	242
	2025	2026	2027	2028	2029	2030	
Number of Kidney Transplants MA & FFS:	21,191	21,826	22,481	23,155	23,850	24,566	
Kidney Transplant Incidence FFS (%):	4.3	4.2	4.2	4.1	4.1	4.0	
Kidney Transplant Incidence MA (%):	2.4	2.6	2.8	3.0	3.2	3.4	
ESRD Enrollment FFS (000's):	354	358	364	369	374	379	
ESRD Enrollment MA (000's):	250	256	261	266	270	274	

Back to Agenda Back to Item

Then we calculate the average kidney acquisition costs using FFS claims data from CMS data systems. The average kidney acquisition costs ranged from $69,000 in 2013 to $83,000 in 2017, which equates to an annual growth rate of 4.7 percent. This percentage was used to estimate average kidney acquisition costs during the projection period of 2018 to 2030.

The gross costs to the FFS program for covering MA kidney acquisition costs are computed by multiplying the MA transplant incidence rate by the number of MA ESRD enrollees multiplied by the average kidney acquisition cost. This computation was completed for the years 2021–2030. The gross costs, as found in the Table 10, range from $298 million in 2021 to $1,384 million in 2030. Again, we apply the government share of the gross savings factors as well as the Part B premium factors to compute the net costs to the Medicare Trust Funds. These factors are the same as those used to calculate the savings for excluding kidney acquisition costs from the MA benchmarks. The net costs to the Medicare Trust Funds after applying these factors are expected range from $212 million in 2021 to $981 million in 2030.

TABLE 10—COSTS TO THE FFS PROGRAM FOR COVERING MA KIDNEY ACQUISITION COSTS

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2021–2030
Kidney Transplant Incidence MA (%):	1.6	1.8	2.0	2.2	2.4	2.6	2.8	3.0	3.2	3.4	
ESRD Enrollment MA (000's):	186	213	231	242	250	256	261	266	270	274	
Avg Kidney Acq Costs ($'s):	99,146	103,804	108,680	113,786	119,131	124,728	130,587	136,722	143,145	149,870	
Gross Costs ($Millions):	297.9	401.3	503.0	605.7	713.5	828.7	950.2	1,082.5	1,226.1	1,383.7	7,992.6
Avg Gov't Share of Gross Savings (%):	83.0	83.0	83.0	83.1	83.2	83.2	83.2	83.4	83.4	83.4	
Net of Part B Premium (%):	85.6	85.6	85.5	85.4	85.3	85.2	85.0	84.9	84.9	84.9	
Net Costs ($Millions):	211.7	284.9	357.0	429.5	506.0	587.1	672.3	766.5	869.1	980.8	5,664.9

Next, we examined the MA cost of kidney acquisition coverage. We used data based on the kidney acquisition costs for the FFS beneficiaries to compute the portion of the MA benchmark that has been attributed to kidney acquisition costs. In order to compute the amount that the MA health plans have been reimbursed for these costs in the past, we tabulated Medicare's share of kidney acquisition costs and the number of Medicare discharges from the Medicare Cost Reports (Form CMS–2552–10) for certified kidney transplant centers. The kidney acquisition costs were computed for the years 2013–2017 (the latest data that was available at the time of this study) using information from the Medicare Cost Reports for FFS beneficiaries at the county-level. The county level per member per month (PMPM) costs are derived by summing the kidney acquisition costs for each county and dividing these amounts by the county specific Medicare FFS enrollment. These annual costs per member are then divided by 12 in order to compute the PMPM's.

Next, we examine the historical kidney acquisition cost PMPM trend for the years 2013–2017 to project these costs for the years 2018–2030. In aggregate, the kidney acquisition PMPM costs grew at an average rate of 6.4 percent during 2013–2017. This trend is used to estimate these costs for the 2018–2030 period.

To calculate the gross savings to the Medicare Trust Funds, we multiply the projected MA enrollment by the annual per member kidney acquisition costs. We then apply two additional factors to the gross savings in order to compute the net savings to the Medicare Trust Funds:

- Average government share of gross savings. Government expenditures are the sum of bids and rebates. Rebates are the portion of the difference between the MA benchmarks and MA bids that the health plans use to pay for additional supplemental benefits or reductions in enrollee cost sharing. The government retains the remaining difference between MA benchmarks and MA bids. We estimate that bids will be reduced by 50 percent of the total reduction in benchmarks.
- Net of Part B premium. Medicare enrollees, not the Trust Funds, are responsible for approximately 25 percent of their Part B costs.

The government share of gross savings factors are expected to be between 83.0 percent and 83.4 percent during the period 2021–2030. The net of Part B premium factors are expected to be 85.6 percent and 84.9 percent during that same period. The results can be found in Table 11. The net savings due to excluding kidney acquisition costs from MA benchmarks is estimated to range from $594 million in 2021 to $1,346 million in 2030.

TABLE 11—PER-YEAR CALCULATIONS, REPRESENTING THE PRE-STATUTE BASELINE BASED ON MEDICARE FFS COVERAGE OF KIDNEY ACQUISITION COST

	2013	2014	2015	2016	2017	2018	2019	2020			
Kidney Acq Costs (PMPM):	1.72	1.82	1.95	2.08	2.20	2.34	2.49	2.65			
	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2021–2030
Kidney Acq Costs (PMPM):	2.82	3.00	3.20	3.40	3.62	3.85	4.10	4.36	4.64	4.94	
Medicare Advantage Enrollment Projection (000's):	24,690	25,624	26,508	27,380	28,237	29,070	29,861	30,607	31,313	32,035	
Gross Savings ($Millions):	836.2	923.5	1,016.6	1,117.4	1,226.3	1,343.4	1,468.4	1,601.7	1,743.7	1,898.4	13,175.6

Back to Agenda Back to Item

TABLE 11—PER-YEAR CALCULATIONS, REPRESENTING THE PRE-STATUTE BASELINE BASED ON MEDICARE FFS COVERAGE OF KIDNEY ACQUISITION COST—Continued

	2013	2014	2015	2016	2017	2018	2019	2020			
Average government share of Gross Savings (%):	83.0	83.0	83.0	83.1	83.2	83.2	83.2	83.4	83.4	83.4	.....
Net of Part B Premium (%): ..	85.6	85.6	85.5	85.4	85.3	85.2	85.0	84.9	84.9	84.9	.....
Net Savings ($Millions):	594.1	655.7	721.5	792.3	869.5	951.7	1,038.9	1,134.1	1,235.9	1,345.6	9,339.3

Comment: A commenter expressed concern about the estimates in the regulatory impact analysis that concluded the net savings attributable to the exclusion of kidney acquisition costs from MA benchmarks exceed the net costs attributable to FFS coverage of kidney acquisition costs. The commenter also pointed to the Congressional Budget Office's November 2016 cost estimate of the Cures Act, which reported no change in federal spending, to underscore the notion that the net savings estimated in the proposed rule were not intended by the change in law.

Response: We thank the commenter for this feedback. Total MA kidney acquisition costs have historically been lower than total FFS kidney acquisition costs for two main reasons: (1) MA transplant incidence has been lower than FFS transplant incidence; and (2) MA ESRD enrollment (as a percent of total MA enrollment) has been lower than FFS ESRD enrollment (as a percent of total FFS enrollment). These factors result in a lower number of MA kidney transplants per capita versus FFS kidney transplants per capita. We expect savings from the exclusion of kidney acquisition costs from the MA benchmarks since MA plans have historically been reimbursed for these costs based on the higher rate of transplantation in FFS. We believe our impact analysis sufficiently outlined why the shift in responsibility from MA to FFS is not budget neutral.

Comment: Some commenters requested that we explain why the estimates in the 2021 Advance Notice appear to diverge from the estimates included in the proposed rule. The commenters indicated that the FFS cost of kidney acquisition would be an estimated $2.82 PMPM while the Advance Notice indicated that the carve-out impact estimate would be $4 PMPM.

Response: The Medicare FFS cost of kidney acquisitions estimate provided in the proposed rule is a national estimate of the impact on the Medicare Trust Funds. In contrast, the preliminary estimate provided in the calendar year 2021 Advance Notice represents a county-level average impact of excluding kidney acquisition costs from FFS experience on the MA non-ESRD county rates. Additionally, the estimates provided in the proposed rule and the Advance Notice were calculated using different trending assumptions and underlying data. The updated estimate of the impact figure that was provided in the calendar year 2021 Advance Notice is $3.

Comment: A few commenters questioned the credibility of county level data in determining the kidney acquisition cost carve-out amounts and requested that CMS release the supporting data and analyses. A commenter specifically pointed to Tables 26 and 27 in the proposed rule, noting that there were approximately 75,000 kidney transplants paid by FFS during 2014–2018 (the data period used to compute the kidney acquisition carve-out amounts). The commenter expressed concern regarding the credibility of using 75,000 events to develop 3,225 county specific carve-out factors, and requested that the kidney acquisition cost factors be developed across broader geographic areas than counties in order to mitigate variability and potential credibility issues that may exist when forecasting county level carve-out amounts.

Response: CMS provided a step-by-step description of the methodology for calculating the kidney acquisition costs to be excluded from the MA benchmarks on pages 25 and 26 of the calendar year 2021 Advance Notice.[55] Consistent with the statutory requirement to exclude the cost of kidney acquisitions for organ transplants from the primary components of the MA capitation rates, CMS finalized the kidney acquisition carve-out methodology after considering all public comments received.

Organ acquisition costs for transplants are paid on a reasonable cost basis, separately from the MS–DRG (Medicare Severity Diagnosis Related Group) payment. Hospitals are paid the estimated amount for these costs through interim biweekly payments throughout the year, referred to as ''pass-through amounts'' (pass-through amounts include other costs as well). For MA rate calculations to date, these FFS pass-through amounts are estimated and specifically added to the inpatient claim records to account for the eventual payment in the FFS program on a reasonable cost basis. The kidney acquisition costs included in the pass-through amounts are added to all discharges from kidney transplant centers by the county of the beneficiary's residence. Since the number of these discharges greatly exceeds the number of transplants, there is sufficient data to calculate credible kidney carve out factors and there is no need to adjust for credibility. Kidney acquisition costs are not allocated by the number of transplants. Since the pass-through KAC amounts are calculated and included at the county level, the carve-out factors must be developed at the county level to be consistent.

Comment: A commenter expressed concern about potential barriers to access to transplantation in MA, citing language in the proposed rule that stated that the transplant incidence rate for ESRD beneficiaries has historically been higher in FFS than in MA.

Response: Our data indicated that MA ESRD enrollees have been in dialysis status for a shorter duration and are typically older than FFS ESRD enrollees. We have observed that in the Medicare program, the incidence of kidney transplants is typically inversely correlated with age; the younger the ESRD enrollee, the more likely that a kidney transplant will occur. Historically, MA enrollees are less likely than FFS enrollees to receive a kidney transplant since the average age of MA ESRD enrollees is higher than the average age of FFS ESRD enrollees. It is our interpretation of this data that on average, older ESRD enrollees are not as likely to be eligible for a kidney transplant due to other underlying health conditions that typically occur as these enrollees age. The 2020 Kidney Disease: Improving Global Outcomes (KDIGO) Clinical Practice Guideline on the Evaluation and Management of Candidates for Kidney Transplantation

[55] The Advance Notice and Rate Announcement for each year are available online at: *https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.*

outlines a comprehensive, evidence-based set of guidelines and recommendations designed to assist health care professionals assess suitability for candidacy for kidney transplantation. While clinicians are advised against excluding patients because of age alone, the guidelines recommend that they consider age in the context of other comorbidities, including frailty, which may affect outcomes. As MA enrollees have typically become eligible for Medicare due to age and disability and are, on average, older than FFS enrollees, MA ESRD enrollees may, on average, be more likely to have comorbidities that make them less suitable for kidney transplantation. As more ESRD beneficiaries enroll in MA plans, we anticipate that the profile of these beneficiaries will change and the difference in the transplant incidence rate for ESRD beneficiaries enrolled in MA and those in FFS will decrease.

After careful consideration of all comments received, we are finalizing the exclusion of kidney acquisition costs from MA benchmarks and coverage under FFS Medicare as proposed.

3. Reinsurance Exceptions (§ 422.3)

It is difficult to determine whether there would be a cost or savings impact to this proposal. The use of reinsurance or other arrangements permitted by the proposal is a choice for MA organizations, which they can exercise if they believe it is in their business interests to purchase. While purchasing reinsurance coverage has a cost associated with it, the use of reinsurance provides financial protection that may generate offsetting savings to the MA organization, or reduce their risk. Therefore, we are unable to quantitatively estimate the impacts of this provision.

We solicited stakeholder comment on (i) how this provision may be used, (ii) likely costs and savings, and (iii) other related impacts. We received no comments on this regulatory impact analysis for this proposal and therefore are finalizing this provision without modification.

4. Medicare Advantage (MA) and Part D Prescription Drug Program Quality Rating System (§§ 422.162, 422.166, 423.182, and 423.186)

We proposed measure updates as well as the methodology changes (concerning outliers and the weight of patient experience/complaints and access measures). These measure updates are routine and do not have an impact on the highest ratings of contracts (that is, overall rating for MA–PDs, Part C summary rating for MA-only contracts, and Part D summary rating for PDPs). These type of routine changes have historically had very little or no impact on the highest ratings. Hence, there will be no, or negligible, impact on the Medicare Trust Fund from the routine changes.

The cost impacts due to the Star Ratings updates are calculated by quantifying the difference in the MA organization's final Star Rating with the final rule and without the final rule. There are two ways that our final rule could cause a contract's Star Rating to change: (1) To increase measure weights for patient experience/complaints and access measures from two to four; and (2) the use of Tukey outlier deletion, which is a standard statistical methodology for removing outliers. There are assumed to be Medicare Trust Fund impacts due to the Star Ratings changes associated with these two revisions to the methodology. The increased measure weights for patient experience/complaints and access revision is assumed to be a cost to the Medicare Trust Fund, as there are more contracts that would see their Star Ratings increase than decrease. The Tukey outlier deletion is assumed to be a saver to the Medicare Trust Fund after the first year, as more contracts would see their Star Ratings decrease rather than increase.

All impacts are considered transfers since no goods or services are increased or decreased.

The impact analysis for the Star Ratings updates takes into consideration the final quality ratings for those contracts that would have Star Ratings changes under this final rule. There are two ways that Star Ratings changes will impact the Medicare Trust Fund:

- A Star Rating of 4.0 or higher will result in a QBP for the MA organization, which, in turn, leads to a higher benchmark. MA organizations that achieve an overall Star Rating of at least 4.0 qualify for a QBP that is capped at 5 percent (or 10 percent for certain counties).
- The rebate share of the savings will be higher for those MA organizations that achieve a higher Star Rating. The rebate share of savings amounts to 50 percent for plans with a rating of 3.0 or fewer stars, 65 percent for plans with a rating of 3.5 or 4.0 stars, and 70 percent for plans with a rating of 4.5 or 5.0 stars.

In order to estimate the impact of the Star Ratings updates, the MA baseline assumptions are updated with the assumed Star Ratings changes described in this final rule. The MA baseline is completed using a complicated, internal CMS model. The main inputs into the MA baseline model include enrollment and expenditure projections. Enrollment projections are based on three cohorts of beneficiaries: (i) Dual-eligible beneficiaries; (ii) beneficiaries with employer-sponsored coverage; and (iii) all others, including individual-market enrollees. MA enrollment for all markets is projected by trending the growth in the penetration rates for the 2011 through 2018 base data. The key inputs for the expenditure projections include the following:

- United States Per Capita Cost (USPCC) growth rates.
- Adjustment to MA risk scores for differences in diagnosis coding between MA and fee-for-service beneficiaries.
- Quality bonus (county-specific).
- Phase-out of Indirect Medical Education (county-specific).

Projections are performed separately for payments from the Part A and Part B trust funds. Aggregate projected payments are calculated as the projected per capita cost times the projected enrollment. The Medicare Trust Fund impacts are calculated by taking the difference of the MA baseline with the Star Ratings changes and the original MA baseline.

The results are presented in Table 12. The last column of Table 12 presents net savings to the Medicare Trust Fund once both provisions are in place; in 2024 the costs are $345.1 million; the net savings will grow over time reaching $999.4 million by 2030. The first year only includes the implementation of the weight change, while future years include both the weight change and Tukey outlier deletion resulting in a change from the first year as a cost to the Medicare Trust Fund to a net savings in future years. The aggregate savings over 2024 to 2030 are $4.1 billion. Ordinary inflation is carved out of these estimates. The source for ordinary inflation is Table II.D.1. of the 2019 Medicare Trustees report. It should be noted that there are inflationary factors that are used in the projected Star Ratings and are used in these estimates. The Star Ratings are assumed to inflate at a higher rate for the lower rated contracts than for the higher rated contracts. MA organizations with low Star Ratings have a better chance of improving their quality ratings than MA organizations that have already achieved a high Star Rating. For instance, a contract with a Star Rating of 4.5 has less room to increase its Star Rating than a contract with a Star Rating of 3.0.

There is a large projected reduction in the costs associated with the increase in the weight of measures classified as

patient experience/complaints and access measures in 2029. This is due to several contracts that are projected to achieve a 4.0 Star Rating in 2029 and are eligible for the QBP at that time, even after this final rule is applied. This narrows the difference in costs between the final rule and the original baseline.

The impact on costs is not seen until 2024 for the increase in weights and 2025 for the Tukey outlier deletion since these policies are being implemented for the 2021 and 2022 measurement years (meaning performance periods), respectively. A change for the 2021 measurement year impacts the 2023 Star Ratings which determines the MA QBPs for the 2024 contract year. Similarly, a change for the 2022 measurement year impacts the 2024 Star Ratings which determines the MA QBPs for the 2025 contract year.

TABLE 12—CALCULATIONS OF NET SAVINGS PER YEAR TO THE MEDICARE TRUST FUND FOR STAR RATINGS UPDATES

Calendar year	Ordinary inflation (%)	Increased cost (weight) in patient access and experience/complaints ($ millions)	Increased cost (weight) in patient access and experience/complaints ($ millions) with ordinary inflation carved out	Savings from Tukey outlier deletion ($ millions)	Savings from Tukey outlier deletion ($ millions) with ordinary inflation carved out	Net savings with ordinary inflation carved out ($ millions)
2024	3.20	391.4	345.1	0	0.0	–345.1
2025	3.20	305.4	260.9	935	798.8	537.9
2026	3.20	296.1	245.1	1,029.00	851.8	606.7
2027	3.20	343.4	275.4	1,110.50	890.8	615.3
2028	3.20	301.1	234.0	1,296.50	1007.7	773.7
2029	2.60	93.9	71.1	1,356.90	1027.9	956.8
2030	2.60	95.7	70.7	1,449.20	1070.0	999.4
Totals with inflation carved out			1502.3		5647.0	4144.6

Note: In all but the last column both costs and savings are expressed as positive numbers. Positive numbers in the last column indicate savings while negative numbers indicate net cost.

We received the following comments on our estimates of cost impacts, and our responses follow.

Comment: A couple of commenters wanted more information on the modeling related to the financial impacts.

Response: The modeling is based on taking the difference of the MA baseline with the Star Ratings changes (Tukey outlier deletion and the weight increase for patient experience/complaints and access measures) and the original MA baseline which is described in the Medicare Trustees Report available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf.* CMS assumptions related to enrollment and revenue growth are available in the Medicare Trustees Report. Some commenters referenced analyses that Wakely [56] conducted that suggested a higher impact for deletion of outliers. As we are implementing these changes on top of guardrails, which will already limit significant movements of cut points from year-to-year, we do not believe that the estimates should be higher than what was included in the notice of proposed rulemaking.

As many commenters noted, the COVID–19 public health emergency does create more uncertainly in terms of how performance and quality metrics will change following the pandemic. At this time there is too much uncertainty to revise these estimates to reflect the impact of the pandemic on quality measure scores. CMS will continue to monitor the impact for additional changes.

Comment: A few commenters mentioned the analysis by Wakely referenced in the prior comment which suggests that CMS may have overestimated the weight impact on Star Ratings for plans. The report also found there is significant year-over-year volatility in average Star Ratings for patient experience/complaints and access measures, despite consistent trends in plan performance over time and that increasing the weight of these measures could impact the stability of the Star Ratings program.

Response: The Wakely report claims that the volatility in cut points over time is primarily driven by the clustering methodology. CMS disagrees with this conclusion. The majority of measures included in the patient experience/complaints and access categories do not use the clustering methodology. CAHPS measure Star Ratings are calculated using relative distribution and significance testing, per §§ 422.166(a)(3) and 423.186(a)(3). CMS has seen over time that changes in measure cut points are primarily driven by differences in the distribution of scores over time and changes in industry performance. It is also not clear whether Wakely took into consideration other changes to the Star Ratings methodology over time, including the retirement of the Part D appeals and BMI measures.

In the proposed rule, CMS proposed outlier deletion using the Tukey outer fence outlier removal. The main objective of removing outliers is to stabilize cut points and prevent large year-to-year fluctuations in cut points. Even for skewed distributions, Tukey outlier removal works to stabilize cut points to avoid substantial year-to-year fluctuations in cut points that can be caused by extreme outliers.

Comment: A couple of commenters questioned the budget estimates for the new policies. They mentioned the Wakely report noting that the report estimated that increasing the weights of patient experience/complaints and access measures in the 2023 Star Ratings would only increase MA plan payments by $83 million—nearly 5 times less than what CMS estimated. A commenter stated that when combined with the proposal to exclude outliers, more MA enrollees would be in plans negatively impacted than those who would see positive results. The commenter requested CMS to first provide more details on its methodology to allow plans to run similar simulations to better understand the impact of the

[56] Wakely Consulting Group. Star Rating Variability of Patient Experience and Access Measures: Analyzing the Impact of Variable Star Rating Cut Points and Measure Level Results. March 2020.

proposed change to the weighting for these measures and plan ratings

Response: It is unclear to CMS how Wakely did their simulations. For example, it appears that Wakely did not understand that the CAHPS measures are not calculated using the clustering methodology, and consequently, Tukey outlier deletion would not be applied to that group of measures. CMS simulations were conducted assuming the implementation of guardrails which limits the fluctuation in cut points and assuming the retirement of the Part D appeals and BMI measures. Wakely stated they applied mean resampling and guardrails to the Star Rating cut points prior to applying Tukey outlier deletion; therefore, the estimated impact of Tukey outlier deletion does not include the impact of mean resampling and guardrails. We specifically proposed that prior to applying mean resampling with hierarchal clustering, Tukey outer fence outliers are removed and this is how CMS conducted the simulations. This may be causing some of the discrepancies. As described above, CMS estimated the change in the ratings of MA contracts and then modeled the cost impact using that information and enrollment and expenditure projections. Enrollment projections are based on three cohorts of beneficiaries: (i) Dual-eligible beneficiaries; (ii) beneficiaries with employer-sponsored coverage; and (iii) all others, including individual-market enrollees. MA enrollment for all markets is projected by trending the growth in the penetration rates for the 2011 through 2018 base data. The key inputs for the expenditure projections include the USPCC growth rates, adjustment to MA risk scores, quality bonuses (county-specific), and phase-out of indirect medical education (county-specific).

After careful consideration of all comments received, and for the reasons set forth in our responses to the related comments summarized earlier, we are finalizing our impact analysis for the Star Ratings updates to include delayed implementation of Tukey outlier deletion by one year.

5. Medical Loss Ratio (MLR) (§§ 422.2420, 422.2440, and 423.2440)

Regulatory Changes to Incurred Claims (§ 422.2420)

As discussed in section IV.D.2 of this final rule, we are finalizing our proposal to amend the regulation at § 422.2420(b)(2)(i) so that the incurred claims portion of the MLR numerator for an MA contract would include all amounts that an MA organization pays (including under capitation contracts) for covered services for all enrollees under the contract. Prior to this regulatory change, § 422.2420(b)(2)(i) specified that incurred claims include direct claims that an MA organization pays to providers as defined in § 422.2 (including under capitation contracts with physicians) for covered services provided to all enrollees under the contract.

We proposed this amendment so that incurred claims in the MLR numerator will include expenditures for certain supplemental benefits that MA organizations are newly authorized to offer to MA enrollees as a result of recent policy and legislative changes. As explained in greater detail in section II.A. of this final rule and sections II.A. and VI.F. of the proposed rule, recent subregulatory guidance and statutory changes have expanded the types of supplemental benefits that MA organizations may offer to enrollees. Beginning in 2020, pursuant to section 1852(a)(3)(D) of the Act, as amended by the BBA of 2018, MA organizations may provide SSBCI. SSBCI can include benefits that are not primarily health related, as long as the item or service has the reasonable expectation to improve or maintain the chronically ill enrollee's health or overall function. In addition, effective January 1, 2019, CMS' interpretation of ''primarily health related benefits,'' which is used as a criterion for supplemental benefits, has been changed to include services or items used to diagnose, compensate for physical impairments, ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization. To be considered ''primarily health related,'' a supplemental benefit must focus directly on an enrollee's health care needs and should be recommended by a licensed medical professional as part of a health care plan, but it need not be directly provided by one.

This impact analysis assumes that the amendments to § 422.2420(b)(2)(i) would not impact MA enrollee benefits. In other words, the analysis assumes the amendments would change the types of expenditures that could be included in the MLR numerator as incurred claims, but there would be no impact on the level or number of permissible enrollee benefits that MA plans elect to offer.

The requirements pertaining to the calculation and reporting of MA contracts' MLRs are presented in 42 CFR part 422, subpart X. MA organizations that do not meet the 85 percent minimum MLR requirement for a contract year are required to remit funds to us (§ 422.2410(b)). We collect remittances by deducting the amounts owed from MA organizations' monthly payments (§ 422.2470(c)). In the absence of statutory language directing us to return remitted funds to the Medicare Trust Fund, we transfer remittances to the Treasury. For purposes of this impact analysis, we assume contracts that have an MLR of less than 85 percent for one contract year do not continue to fail to meet the MLR requirement for an additional two consecutive contract years, which would result in imposition of enrollment sanctions, or for an additional four consecutive contract years, which would result in contract termination. This is consistent with our experience; although the MLR requirement has only been in effect for five contract years, to date, very few contracts have been subject to MLR-related enrollment sanctions, and only one contract has failed to meet the MLR requirement for more than three consecutive contract years. No contract has been terminated for failure to meet the MLR requirement for five consecutive contract years.

Total remittances for individual contract years can be substantial. Based on internal CMS data, the simple average of total remittances across all contracts for contract years 2014—2017 is $131 million. If we adjusted these payments to a 2017 level by trending for enrollment and per capita growth but carving out ordinary inflation, the average would be $139 million.

We anticipate that the amendments to § 422.2420(b)(2)(i), which we are finalizing in this final rule, would increase the numerator of the MLR because the incurred claims category would include certain expenditures that would not qualify for inclusion in the numerator under the current regulations. Specifically, under the amendments to § 422.2420(b)(2)(i) that we are finalizing, incurred claims would include amounts that an MA organization pays (including under capitation contracts) for covered services, regardless of whether payment is made to an individual or entity that is a provider as defined at § 422.2. We expect that this will cause some MA contracts which formerly would not have satisfied the 85 percent minimum MLR requirement to now meet or exceed it. For contracts that still fail to meet the 85 percent threshold, we anticipate that the amount of remittances would decrease. In other words, we anticipate that the amendments to § 422.2420(b)(2)(i) that we are finalizing will effectively result in a transfer of funds from the Treasury

to the MA organizations through the Medicare Trust Fund. Amounts that MA organizations would remit and which the Treasury would receive under the regulations prior to their amendment by this final rule will instead remain with the MA organizations, implying that MA organizations will enjoy cost savings while the Treasury has a cost impact. The net impact on the Medicare Trust Fund is expected to be zero, since there will be no additional transfers from or to the Medicare Trust Fund; the only issue will be whether the MA organizations retain additional funds or the Treasury receives fewer funds.

To estimate the amount of payments made for services that would be included in incurred claims under the amendments to § 422.2420(b)(2)(i) that we are finalizing, we used data in the 2019 submitted bids to estimate the increase in the supplemental benefits category for the primarily health related benefits that MA organizations could include in their PBPs starting in 2019. This estimate is complicated by the fact that, in the absence of the amendments to § 422.2420(b)(2)(i), some types of supplemental benefits that MA organizations could offer starting in 2019 could potentially meet the requirements at § 422.2430 to be quality improvement activities (QIAs) for MLR purposes, meaning expenditures for those benefits could be included in the MLR numerator. Based on the 2019 submitted bid information, a consideration of the types of benefits that MA organizations could offer under our reinterpretation of the ''primarily health related'' definition, and the likelihood that some of these benefits would meet the requirements at § 422.2430(a) to be QIAs, we estimated a 52 percent increase in projected expenditures for the categories of ''primarily health related'' supplemental benefits that would not qualify for inclusion in the MLR numerator as ''incurred claims'' under § 422.2420(b)(2)(i), as defined prior to the amendment that we are finalizing in this final rule, or as QIA under § 422.2430(a). The first year that the expanded interpretation of ''primarily health related benefits'' was implemented was 2019, and so the increase seen in these categories for 2019 is attributed to this reinterpretation. To date, MA organizations have only been able to include non-primarily health related SSBCI in their plan offerings for one year (that is, 2020). While early indications show that utilization for these benefits have been low, we expect the use of these benefits to grow over time as MA organizations become more familiar with them and have time to include them in future plan offerings. Due to the absence of credible data for SSBCI, the impact on future MLR remittances is currently unquantifiable. We will continue to track SSBCI information and adjust the forecasts as more information becomes available.

We then reevaluated the MLRs for those contracts that failed to meet the 85 percent MLR requirement for contract years 2014—2017 by revising the numerator calculation to incorporate the 52 percent increase in the previously listed benefits. The change in the numerator calculation resulted in several of the contracts passing the MLR requirement instead of failing. For contracts that would not have met the MLR requirement even with the revised numerator calculation, the amount of remittances decreased. The average decrease in remittance payments over the four-year period (that is, 2014—2017) is estimated to be $25.8 million (in 2017 dollars).

In order to project the decrease in remittances for the years 2021—2030, the $25.8 million was increased using estimated enrollment and per capita increases based on Tables IV.C1 and IV.C3 of the 2019 Medicare Trustees Report, with ordinary inflation (Table II.D1 of the 2019 Medicare Trustees Report) carved out of the estimates.

The results are presented in Table 13, which shows that for the first year of the finalized provision, 2021, there will effectively be a transfer from the Treasury through the Medicare Trust Fund of $35.3 million to MA organizations. (For computational transparency, the table also shows the amounts that would have been transferred to MA organizations for 2017—2020 if the change we are finalizing in this final rule had been in place in those years.) This transfer is in the form of a reduction in the remittance amounts withheld from MA capitated payments. This amount (that is, the amount of remittances *not* withheld from MA capitated payments under the finalized provision) is projected to grow over 10 years, resulting in a $56.4 million transfer from the Treasury through the Medicare Trust Fund to MA organizations in 2030. The total transfer from the Treasury to MA organizations over 10 years is $455 million. There is $0 impact on the Medicare Trust Fund.

TABLE 13—TRANSFER OF REMITTANCES FROM THE TREASURY TO MA ORGANIZATIONS

Year	Medicare Advantage enrollment increase	Average annual per capita increase %	Ordinary inflation	Net costs ($ millions)
2017				25.8
2018	7.7	5.5	3.2	28.4
2019	6.7	5.5	3.2	31.0
2020	5.0	5.5	3.2	33.3
2021	3.6	5.5	3.2	35.3
2022	3.8	5.5	3.2	37.5
2023	3.5	5.5	3.2	39.7
2024	3.3	5.5	3.2	41.9
2025	3.1	5.5	3.2	44.2
2026	3.0	5.5	3.2	46.5
2027	2.7	5.5	3.2	48.8
2028	2.5	5.5	3.2	51.1
2029	2.3	5.5	2.6	53.8
2030	2.0	5.5	2.6	56.4
Total 2021–2030				455.2

Back to Agenda Back to Item

We received no comments on our impact analysis and are finalizing the proposal without modification.

Deductible Factor for MA Medical Savings Account (MSA) Contracts (§ 422.2440)

As discussed in section IV.D.4. of this final rule, we are finalizing our proposal to amend § 422.2440 to provide for the application of a deductible factor to the MLR calculation for MA MSA contracts that receive a credibility adjustment. The deductible factor will serve as a multiplier on the credibility factor. We are also finalizing our proposal to adopt and codify in new paragraph (g) of § 422.2440 the same deductible factors that appear in the commercial MLR regulations at 45 CFR 158.232(c)(2). For partially credible MA MSA contracts, the deductible factor will range from 1.0 for MA MSA contracts that have a weighted average deductible of less than $2,500 to 1.736 for MA MSA contracts have a weighted average deductible of $10,000 or more.

In section IV.D.4. of this final rule, we explain that we proposed to add a deductible factor to the MLR calculation for MSAs so that organizations currently offering MSA plans, or those that are considering entering the market, are not deterred from offering MSAs due to concern that they will be unable to meet the MLR requirement as a result of random variations in claims experience. Although we believe that the deductible factors would adequately address any such concerns by making it less likely that an MSA contract will fail to meet the MLR requirement due to random variations in claims experience, we are uncertain whether or how the proposed change to the MLR calculation for MA MSA contracts will impact the availability of MA MSAs or the number of beneficiaries enrolled in MA MSAs. Due to this uncertainty, we estimate that the cost impact of the change to the MLR calculation for MA MSAs will be as low as $0 or as high as $40 million over 10 years (2021–2030).

We do not anticipate that applying a deductible factor to the MLR calculation for MA MSA contracts will have an impact on remittances to the federal government. For contract years 2014–2018 (the most recent contract year for which MA MSAs have submitted MLR data), no MA MSA contract has failed to meet the 85 percent minimum MLR requirement. If the deductible factor had applied to the MLR calculation for MA MSAs for contract years 2014–2018, although the MLRs for partially credible MA MSAs would have been higher, total remittances by MA MSAs would have remained at $0. We do not anticipate that MSA contracts that currently meet the MLR requirement will have more difficulty doing so after the deductible factor is applied to the MLR calculation, starting in contract year 2021. We anticipate that new MA MSA contracts that MA organizations may choose to offer as a result of this regulatory change will also succeed in meeting the MLR requirement, in light of the experience of current MSAs and in consideration of the more generous credibility adjustment that potential new MSAs would be expected to receive as a result of the application of the deductible factor.

We believe that the cost impact of this regulatory change, if any, will be attributable to an increase in MA MSA enrollment as these plans become more widely available as a result of MA organizations choosing to offer MA MSAs in response to the change to the MLR calculation. To develop the upper limit of the cost estimate for this impact analysis ($40 million over 10 years), we assumed that the change to the MLR calculation for MSAs would cause MA MSA enrollment to double over the first 3 years that the change is in effect. We estimated that, relative to previous enrollment projections that did not account for the amendments that we are finalizing in this final rule, this regulatory change MSA enrollment will be 33.33 percent higher in 2022, 66.67 percent higher in 2023, and 100 percent higher in 2024 to 2030. We assumed that half of the new enrollees in MA MSA plans would otherwise have been enrolled in other types of MA plans, and half would otherwise have been enrolled in FFS Medicare.

We did consider the migration patterns for EGWP ESRD beneficiaries versus Individual ESRD beneficiaries. We surmised that the costs differences between EGWP and Individual ESRD coverages are not significant enough to display the migration patterns separately. Displaying projections at that coverage level would not provide further understanding of the financial projections since the cost differences are not too different. Furthermore, EGWP plans have not submitted bids since 2017 and their payments are based on aggregated Individual bids so the cost differences would not be expected to be too different.

We then determined the difference between the amount we pay for each MA MSA plan enrollee and the amount we pay for each enrollee in a non-MSA MA plan or FFS Medicare. We generally incur greater costs for MA MSA enrollees relative to enrollees in other MA plans because 100 percent of the difference between the MA MSA's projection of the cost of A/B services (referred to as the MSA premium) and the benchmark is deposited in the enrollee's account. By contrast, for non-MSA MA plans that bid under the benchmark, we retain between 30 percent and 50 percent of the amount by which the benchmark exceeds the bid. FFS spending per enrollee is approximately 100 percent of the amount we pay to MA plans for each enrollee. Therefore, the cost to the Medicare program for each additional MA MSA enrollee is approximately the same regardless of whether the enrollee would otherwise have been enrolled in a non-MSA MA plan or in FFS Medicare.

The estimated annual cost to the Medicare Trust fund by contract year is presented in Table 14. This estimate takes into account the projected growth in MSA enrollment in the part C baseline projection supporting the Mid-Session Review of the FY 2020 President's Budget. The estimated annual cost reflects the additional cost to the Medicare program for each beneficiary who enrolls in an MA MSA plan in lieu of a non-MSA MA plan or FFS Medicare, multiplied by the projected increase in the number of enrollees in MA MSA plans.

TABLE 14—ESTIMATED COST PER YEAR TO THE MEDICARE TRUST FUND FOR CHANGES TO MLR CALCULATION FOR MA MSA CONTRACTS

Contract year	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2021–2030
Annual cost (millions)	$0.0	$1.2	$2.4	$4.0	$4.4	$4.8	$5.2	$5.6	$6.0	$6.4	$40.0
Proposed Annual Increase in MA MSA Enrollment	0	2,604	5,453	8,531	8,876	9,213	9,531	9,833	10,118	10,354	

Back to Agenda Back to Item

We received no comments on our impact analysis and are finalizing the proposal without modification.

6. Medicare Advantage (MA) and Cost Plan Network Adequacy (§§ 417.416 and 422.116)

Our final rule codifies the standards and methodology used currently, with some modifications, to evaluate network adequacy for MA plans and section 1876 cost plans; the final rule includes the list of provider and facility specialty types subject to network adequacy reviews, county type designations and ratios, maximum time and distance standards and minimum number requirements. The final rule also formalizes the CMS exceptions process and requires the annual publishing of the Health Services Delivery (HSD) reference file, which will provide updated numbers and maximums for these standards in subsequent years, and the Provider Supply File, which lists available providers and facilities, including their corresponding office locations and specialty types. CMS will continue to use the current PRA-approved collection of information in conjunction with the HPMS Network Management Module as a means for MA organizations to submit network information when required. As this has been the process for conducting network adequacy reviews since 2016, we do not expect any additional burden on MA plans as it relates to the network adequacy review process.

Our final rule is solely related to the sufficiency of contracted networks that MA organizations must maintain and has no impact on the provision of Medicare benefits that must be provided in either in-network and out-of-network settings. As a result, we do not expect any impact on the Medicare Trust Fund.

However, we are finalizing three modifications to current network adequacy policy that may have qualitative impacts on MA organizations. In Micro, Rural, and CEAC county designation types, we are reducing the percentage of beneficiaries residing within maximum time and distance standards from 90 percent to 85 percent. We will allow for a 10-percentage point credit towards the percentage of beneficiaries residing within maximum time and distance when MA organizations contract with one or more telehealth providers in the specialties of Dermatology, Psychiatry, Neurology, Otolaryngology, Cardiology, Ophthalmology, Allergy and Immunology, Nephrology, Primary Care, Gynecology/OB/GYN, Endocrinology, and Infectious Diseases. Similarly, MA organizations may receive a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards for affected provider and facility types in states that have CON laws, or other state imposed anti-competitive restrictions, if the laws limit the number of providers or facilities in a county or state.

With respect to the reduction in percentage of beneficiaries residing within maximum time and distance standards in rural counties, we expect that MA organizations will have a greater likelihood of complying with our reduced percentage in the initial network submission and will not need to request an exception for CMS's consideration. It is not possible to fully quantify the level of effort or hours required for an MA organization to submit an exception request, as they are submitted for multiple reasons. However, generally, we expect that this change will decrease the administrative burden on MA organizations when going through the network review process. Conceivably, the administrative costs included in an MA organization's bid could decrease. However, the decrease in administrative burden could be offset by the increase in administrative burden of contracting with telehealth providers. Additionally, more MA organizations may consider providing contracted services in areas that have traditionally been difficult to establish a sufficient network. The ability to meet compliance standards in new markets is a reasonable factor that may drive MA organization behavior, but we cannot quantify the likelihood of this, as many other factors are considered when entering new markets. In theory, the reduction in the rural percentage could conceivably increase MA enrollment, however our enrollment projections currently do not consider health plans' network adequacy information, and any changes to enrollment projections would be very minor.

By crediting MA organizations 10-percentage points towards the percentage of beneficiaries residing within time and distance standards for contracting with telehealth providers for certain specialties, we anticipate that this will be one of many factors that will help encourage MA organizations to contract with providers that offer telehealth services. However, we do not expect this policy change to significantly alter MA organization contracting patterns related to telehealth providers.

For the 10-percentage point credit for affected providers and facilities in states with CON laws, we expect that MA organizations will have a greater likelihood of complying with network adequacy standards in the initial network submission and will not need to request an exception for CMS's consideration. As we discussed earlier, it is not possible to fully quantify the level of effort or hours required for an MA organization to submit an exception request, but it is possible the administrative costs included in an MA organization's bid could decrease. However, we believe time associated with completing exception requests is nominal will not have a significant impact on the overall administrative costs submitted in a plan's bid.

In summary, we believe this proposal will have a non-quantifiable, negligible economic impact. We received no comments on the regulatory impact of this proposal, and therefore, we are finalizing this provision without modification.

E. Alternatives Considered

We intend to address the proposals that had Alternatives Considered sections from the February 2020 proposed rule in subsequent rulemaking. CMS did not develop Alternatives Considered sections for most of the provisions in this final rule as they generally are direct implementations of federal laws or codifications of existing policy for the Part C and D programs. In this section, CMS includes discussions of Alternatives Considered for the provisions to which they are applicable.

1. Medicare Advantage (MA) Plan Options for End-Stage Renal Disease (ESRD) Beneficiaries (§§ 422.50, 422.52, and 422.110)

We have considered alternatives to estimated costs to the Medicare Trust Funds for removing the prohibition for ESRD beneficiaries to enroll in MA plans. Table 7 above displays the baseline scenario that ESRD enrollment in MA plans is expected to increase by 83,000 due to the Cures Act provision. This increase is assumed to be phased in over 6 years, with half of the beneficiaries (41,500) enrolling during 2021. Table 7 shows the net cost to range from $23 million in CY 2021 to $440 million in CY 2030 which sums to $2.66 billion cost for those 10 years.

The upper scenario uses the assumption that the entire ESRD enrollment increase in MA plans of 83,000 will occur in 2021. All other assumptions are expected to remain the same as those in the baseline. Under this upper scenario, net costs are expected to range from $45 million in CY 2021 to $440 million in CY2030

which sums to $2.73 billion cost for the 10 year projection period.

The lower scenario uses a slower ESRD enrollment increase assumption. Under this scenario, the ESRD enrollment will linearly increase from 8,300 in 2021 to 83,000 in 2030. All other assumptions are expected to remain the same as those in the baseline. Under this lower scenario, net costs are expected to range from $5 million in CY 2021 to $440 million in CY2030 which sums to $1.87 billion cost for the 10 year projection period.

2. Medicare Advantage (MA) and Part D Prescription Drug Program Quality Rating System (§§ 422.162, 422.164, 422.166, 422.252, 423.182, 423.184, and 423.186)

We have considered alternative methodologies for deleting outliers prior to clustering for determining cut points for non-CAHPS measures for the Star Ratings program.

For example, we have considered trimming, which removes scores below and above a certain percentile. As stated in the NPRM, this methodology would remove scores regardless of whether they are true outliers; thus, this methodology would not meet the policy goal of removing outliers as well as the approach we proposed and might not have a negligible impact on the cost estimates.

For the Tukey outlier deletion provision as described in section VIII.D.5. of this final rule, we considered which year it should begin. In the NPRM we proposed for it to begin for the 2021 measurement year, which impacts the 2023 Star Ratings and 2024 Quality Bonus Payment ratings. To provide more time for the healthcare delivery system to adapt to changes from the COVID–19 pandemic, we are finalizing a delay until the 2022 measurement year, which impacts the 2024 Star Ratings and the 2025 Quality Bonus Payment ratings. The cost impact of this change is $713 million (that is, this amount will not be saved from the Medicare Trust Fund in 2024).

We have also considered alternatives to the doubling of the weight from 2 to 4 for patient experience/complaints measures and access measures for the Star Ratings program as described in section VIII.D.5. of this final rule. For example, we considered a weight increase to 3 or 5 for these measures. With a weight increase to 3, there are very small changes in the number of contracts that would increase their highest Star Rating, resulting in negligible impacts on Quality Bonus Payments and costs to the Medicare Trust Fund relative to a weight of 4. Similarly, if we were to increase the weight even further to 5, we anticipate even greater impacts on the Quality Bonus Payments and, consequently, costs to the Medicare Trust Fund.

Finally, we considered delaying any weight increase given the uncertainty about how COVID–19 will impact the healthcare system; however, we decided to proceed to further emphasize the importance of patient experience/complaints measures and access measures.

3. Medical Loss Ratio (MLR) (§§ 422.2420, 422.2440, and 423.2440)

We considered finalizing the proposal to add a deductible factor to the MLR calculation for MA MSA contracts (section VIII.D.6. of this final rule) with an applicability date of January 1, 2022, rather than January 1, 2021, since this rule is not being finalized until after the deadline for MA organizations to apply to offer MSA plans in 2021. However, as discussed in greater detail in section IV.D.4. of this final rule, we believe that the credibility factors used to adjust the MLRs of low enrollment contracts do not adequately account for the impact of claims variability on the MLRs of high deductible MSA contracts. We therefore believe it is appropriate that we finalize the provision to add a deductible factor to the MLR calculation for MA MSA contracts with an applicability date of January 1, 2021, as this will allow the deductible factor to be applied when calculating the contract year 2021 MLRs for current MA MSA contracts. However, as no current MA MSA contract has failed to meet the minimum MLR requirement for a previous contract year, we do not anticipate that applying a deductible factor to those contracts' contract year 2021 MLRs will have an impact on remittances.

F. Accounting Statement and Table

The following table summarizes savings, costs, and transfers by provision. As required by OMB Circular A–4 (available at *https://obamawhitehouse.archives.gov/omb/circulars_a004_a-4/*), in Table 15, we have prepared an accounting statement showing the savings, costs, and transfers associated with the provisions of this final rule for calendar years 2021 through 2030. Table 15 is based on Tables 16A, 16B, and 16C which lists savings, costs, and transfers by provision. Table 15 is expressed in millions of dollars with both costs and savings listed as positive numbers; aggregate impact is expressed as a negative number (cost versus savings). The sign of the transfers follow the convention of Table 16 with positive numbers reflecting costs (as transfers) to government entities (the Medicare Trust Fund and the Treasury) and negative numbers reflecting savings to government entities. As can be seen, the net annualized impact of this rule is a cost of about $1.9 million per year. The raw aggregate cost over 10 years is $18.5 million. Due to transfers, there is net annualized reduced spending by government agencies (the Medicare Trust Fund and Treasury) of $290–$335 million. A breakdown of these savings from various perspectives may be found in Table 16.

TABLE 15—ACCOUNTING TABLE

(millions $) *

Item	Annualized at 7%	Annualized at 3%	Period	Who is impacted
Net Annualized Monetized Savings.	(1.9)	(1.9)	Contract Years 2021–2030	Federal government, MA organizations and Part D Sponsors.
Annualized Monetized Savings.			Contract Years 2021–2030	
Annualized Monetized Cost	1.9	1.9	Contract Years 2021–2030	Federal government, MA organizations and Part D Sponsors.

Back to Agenda Back to Item

TABLE 15—ACCOUNTING TABLE—Continued

(millions $) *

Item	Annualized at 7%	Annualized at 3%	Period	Who is impacted
Transfers	(293.7)	(334.5)	Contract Years 2021–2030	Transfers between the Dept of Treasury and CMS (Medicare Trust Fund, Plans, and Sponsors).

* The ESRD enrollment and Kidney acquisition cost provisions which affected the pre-statutory baseline but did not further impact the codifications of this rule would have added $128.3 and $113.1 million respectively in annualized transfer savings, resulting in total annualized transfer savings of $421.99 and $447.65 savings at 7 percent and 3 percent respectively. *Note:* Negative numbers indicate a net reduction in dollar spending by the government.

The following Table 16 summarizes savings, costs, and transfers by provision and forms a basis for the accounting table. For reasons of space, Table 16 is broken into Table 16A (2021 through 2024), Table 16B (2025 through 2028), and Table 16C (2029–2030), as well as raw totals. In these tables, all numbers are positive; positive numbers in the savings columns indicate actual dollars saved while positive numbers in the costs columns indicate actual dollars spent; the aggregate row indicates savings less costs and does not include transfers. All numbers are in millions. Tables 16A, B, and C form the basis for Table 15.

Back to Agenda Back to Item

Back to Agenda

Back to Item

TABLE 16A: AGGREGATE SAVINGS, COST, AND TRANSFERS IN MILLIONS BY PROVISION AND YEAR FROM 2021 THROUGH 2024

	2021 Savings	2021 Cost	2021 Transfers	2022 Savings	2022 Cost	2022 Transfers	2023 Savings	2023 Cost	2023 Transfers	2024 Savings	2024 Cost	2024 Transfers
Total Savings	-			-			-			-		
Total Costs		2.1			1.8			1.8			1.8	
Aggregate Total	(2.1)			(1.8)			(1.8)			(1.8)		
Total Transfers			35.3			38.1			40.9			389.0
Health Plan Quality Rating system												345.1
Medical Loss Ratio Regulation			35.30			37.50			39.70			41.9
MSA MLR						0.6			1.2			2.0
SSBCI		2.1			1.8			1.8			1.8	

TABLE 16B: AGGREGATE SAVINGS, COST, AND TRANSFERS IN MILLIONS BY PROVISION AND YEAR FROM 2025 THROUGH 2028

	2025 Savings	2025 Cost	2025 Transfers	2026 Savings	2026 Cost	2026 Transfers	2027 Savings	2027 Cost	2027 Transfers	2028 Savings	2028 Cost	2028 Transfers
Total Savings	-			-			-			-		
Total Costs		1.8			1.8			1.8			1.8	
Aggregate Total	(1.8)			(1.8)			(1.8)			(1.8)		
Total Transfers			(491.5)			(557.8)			(563.9)			(719.8)
Health Plan Quality Rating system			(537.9)			(606.7)			(615.3)	-		(773.7)
Medical Loss Ratio Regulation			44.2			46.5			48.8			51.1
MSA MLR			2.2			2.4			2.6			2.8
SSBCI		1.8			1.8			1.8			1.8	

TABLE 16C—AGGREGATE SAVINGS, COST, AND TRANSFERS IN MILLIONS BY PROVISION AND YEAR FROM 2029 THROUGH 2030 AND RAW TOTALS

	2029 Savings	2029 Cost	2029 Transfers	2030 Savings	2030 Costs	2030 Transfers	Raw 10 year totals (savings)	Raw 10 year totals (costs)	Raw 10 year totals (transfers)
Total Savings									
Total Costs		1.8			1.8			18.5	
Aggregate Total	(1.8)			(1.8)			(18.5)		
Total Transfers			(900.0)			(939.8)			(3,669.4)
Health Plan Quality Rating system			(956.8)			(999.4)			(4,144.6)
Medical Loss Ratio Regulation			53.8			56.4			455.2
MSA MLR			3.0			3.2			20.0
SSBCI		1.8			1.8			18.5	

The following information supplements Table 16 and also identifies how impacts calculated in section VII of this final rule affect the calculations of this section and the tables.

- Table 16 includes a row for the paperwork burden of the SSBCI provision, whose impact is about $1 million a year.
- For the transfer rows, positive numbers indicate transfers that result in increased dollar spending by the government, while negative numbers indicate transfers that result in reduced dollar spending by the government. Costs are expressed as positive numbers; however, net savings are expressed as negative numbers to reflect that the net impact is a cost, not a savings.
- For two provisions, Parts C and D SEPs, and ESRD enrollment, calculations of impact, either paperwork impact or Medicare Trust Fund impact, have been provided in the narrative along with tables providing 10-year summaries. However, since these impacts are already reflected in current spending, in other words, since the provisions do not change current spending, these impacts have not been included in Table 16. Similarly, as explained the section VII, since the SSBCI paperwork burden is already being spent (similar to SEP), the burden is not included in the summary table.
- Besides the enrollment burden for the SEP provision, there is an additional cost of $0.5 million arising from burden to beneficiaries for filling out enrollment forms in several provisions. These costs have been duly noted in section VII of this final rule but were not included in Table 16 since Table 16 deals mainly with impacts on the Medicare Trust Fund and industry.
- For two provisions, D–SNP look alike and MSA MLR, the impact calculated in section VII of this final rule is $0.0 million and hence these amounts are not included in Table 16. They are however included in Table 6 of section VII of this final rule.

We received comments on impacts in certain individual provisions. These comments as well as our responses have been addressed in the appropriate provision sections above. However, none of these comments led to changes in impacts. Additionally, we did not receive any comments on the summary or monetized table and are therefore finalizing these numbers as is with appropriate adjustments for provisions not included in this first final rule.

G. Conclusion

As indicated in Table 16, while the SSBCI provision has a paperwork burden of about $1 million per year, the other provisions of this final rule are all classified as transfers because consumption of goods or usage of services is neither increased nor decreased. However, we note that the provisions of this part 1 of this final rule will reduce dollar spending of the government by about $300 million a year. The primary driver of this is the Tukey outlier provision.

As indicated in Table 16, the government agencies have a net reduction in spending of $3.65 billion over 10 years. The driver of reduction is the use of the Tukey outlier deletion for Star Ratings after the first year of implementation. Other provisions also affect government spending: (1) The MLR provisions will reduce civil penalties to the Treasury by about 0.46 billion; (2) the MLA MSR provisions will cost the government an extra $40 million due to increased spending on benefits arising from expected increased MSA enrollment; (3) the increased weight in patient experience/complaints and access measures and Tukey outlier deletion in the health plan quality rating system (Star Ratings) will reduce Medicare Trust Fund spending by about $1.5 billion.

H. Reducing Regulation and Controlling Regulatory Costs

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017, and requires that the costs associated with significant new regulations ''shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.'' This rule has an aggregate cost of $1 million a year arising from paperwork burden associated with the SSBCI provision, and consequently, this rule is classified as a regulatory action for the purposes of Executive Order 13771. At a 7 percent rate, this rule is estimated to cost $1.2 million a year in 2016 dollars over an infinite horizon.

List of Subjects

42 CFR Part 417

Administrative practice and procedure, Grant programs-health, Health care, Health insurance, Health maintenance organizations (HMO), Loan programs-health, Medicare, and Reporting and recordkeeping requirements.

42 CFR Part 422

Administrative practice and procedure, Health facilities, Health maintenance organizations (HMO), Medicare, Penalties, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 423

Administrative practice and procedure, Emergency medical services, Health facilities, Health maintenance organizations (HMO), Medicare, Penalties, Privacy, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS

■ 1. The authority citation for part 417 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh, 42 U.S.C. 300e, 300e–5, and 300e–9, and 31 U.S.C. 9701.

■ 2. Section 417.416 is amended by adding paragraph (e)(3) to read as follows:

§ 417.416 Qualifying condition: Furnishing of services.

* * * * *

(e) * * *

(3) The HMO or CMP must meet network adequacy standards specified in § 422.116 of this chapter.

PART 422—MEDICARE ADVANTAGE PROGRAM

■ 3. The authority citation for part 422 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 4. Section 422.3 is added to read as follows:

§ 422.3 MA organizations' use of reinsurance.

(a) An MA organization may obtain insurance or make other arrangements for the cost of providing basic benefits to an individual enrollee in either of the following ways—

(1) The MA organization must retain risk for at least the first $10,000 in costs per individual enrollee for providing basic benefits during a contract year; or

(2) If the MA organization uses insurance or makes other arrangements for sharing such costs proportionately on a per member per year first dollar basis, the MA organization must retain risk based on the following:

(i) The actuarially equivalent value of the retained risk is greater than or equal to the value of risk retained in paragraph (a)(1) of this section.

(ii) The MA organization makes a determination of actuarial equivalence based on reasonable actuarial methods. For example, a reasonable method for determining actuarial equivalence would be to equate the percentage of net claim costs that the MA organization would retain under paragraphs (a)(1) and (a)(2)(i) of this section.

(b) In evaluating compliance with section 1855(b) of the Act and with paragraph (a) of this section, CMS will consider a parent organization and any of its subsidiaries to be part of the MA organization.

(c) The type of payment arrangement used between an MA organization and contracting physicians, other health professionals or institutions for the financial risk specified in section 1855(b)(4) of the Act (that is, the financial risk on a prospective basis for the provision of basic benefit by those physicians or other health professionals or through those institutions) is not limited by paragraph (a) of this section.

§ 422.50 [Amended]

■ 5. Section 422.50 is amended in paragraph (a)(2) introductory text by removing the phrase ''Has not been'' and adding in its place the phrase ''For coverage before January 1, 2021, has not been''.

§ 422.52 [Amended]

■ 6. Section 422.52 is amended in paragraph (c) by removing the phrase ''CMS may waive § 422.50(a)(2)'' and adding in its place the phrase ''For plan years beginning before January 1, 2021, CMS may waive § 422.50(a)(2)''.

■ 7. Section 422.62 is amended by—

■ a. Revising paragraphs (b) introductory text and (b)(3) introductory text;

■ b. Redesignating paragraph (b)(4) as paragraph (b)(26); and

■ c. Adding a new paragraph (b)(4) and paragraphs (b)(5) through (25).

The revisions and additions read as follows:

§ 422.62 Election of coverage under an MA plan.

* * * * *

(b) *Special election periods (SEPs).* An individual may at any time (that is, not limited to the annual coordinated election period) discontinue the election of an MA plan offered by an MA organization and change his or her election from an MA plan to original Medicare or to a different MA plan under any of the following circumstances:

* * * * *

(3) The individual demonstrates to CMS that—

* * * * *

(4) The individual is making an MA enrollment request into or out of an employer sponsored MA plan, is disenrolling from an MA plan to take employer sponsored coverage of any kind, or is disenrolling from employer sponsored coverage (including COBRA coverage) to elect an MA plan. This SEP is available to individuals who have (or are enrolling in) an employer or union sponsored MA plan and ends 2 months after the month the employer or union coverage of any type ends. The individual may choose an effective date that is not earlier than the first of the month following the month in which the election is made and no later than up to 3 months after the month in which the election is made.

(5) The individual is enrolled in an MA plan offered by an MA organization that has been sanctioned by CMS and elects to disenroll from that plan in connection with the matter(s) that gave rise to that sanction.

(i) Consistent with disclosure requirements at § 422.111(g), CMS may require the MA organization to notify current enrollees that if the enrollees believe they are affected by the matter(s) that gave rise to the sanction, the enrollees are eligible for a SEP to elect another MA plan or disenroll to original Medicare and enroll in a PDP.

(ii) The SEP starts with the imposition of the sanction and ends when the sanction ends or when the individual makes an election, whichever occurs first.

(6)(i) The individual is enrolled in a section 1876 cost contract that is not renewing its contract for the area in which the enrollee resides.

(ii) This SEP begins December 8 of the then-current contract year and ends on the last day of February of the following year.

(7) The individual is disenrolling from an MA plan to enroll in a Program of All-inclusive Care for the Elderly (PACE) organization or is enrolling in an MA plan after disenrolling from a PACE organization.

(i) An individual who disenrolls from PACE has a SEP for 2 months after the effective date of PACE disenrollment to elect an MA plan.

(ii) An individual who disenrolls from an MA plan has a SEP for 2 months after the effective date of MA disenrollment to elect a PACE plan.

(8) The individual terminated a Medigap policy upon enrolling for the first time in an MA plan and is still in a ''trial period'' and eligible for ''guaranteed issue'' of a Medigap policy, as outlined in section 1882(s)(3)(B)(v) of the Act.

(i) This SEP allows an eligible individual to make a one-time election to disenroll from his or her first MA plan to join original Medicare at any time of the year.

(ii) This SEP begins upon enrollment in the MA plan and ends after 12 months of enrollment or when the individual disenrolls from the MA plan, whichever is earlier.

(9) Until December 31, 2020, the individual became entitled to Medicare based on ESRD for a retroactive effective date (whether due to an administrative delay or otherwise) and was not provided the opportunity to elect an MA

plan during his or her Initial Coverage Election Period (ICEP).

(i) The individual may prospectively elect an MA plan offered by an MA organization, provided—

(A) The individual was enrolled in a health plan offered by the same MA organization the month before their entitlement to Parts A and B;

(B) The individual developed ESRD while a member of that health plan; and

(C) The individual is still enrolled in that health plan.

(ii) This SEP begins the month the individual receives the notice of the Medicare entitlement determination and continues for 2 additional calendar months after the month the notice is received.

(10) The individual became entitled to Medicare for a retroactive effective date (whether due to an administrative delay or otherwise) and was not provided the opportunity to elect an MA plan during their initial coverage election period (ICEP). This SEP begins the month the individual receives the notice of the retroactive Medicare entitlement determination and continues for 2 additional calendar months after the month the notice is received. The effective date would be the first of the month following the month in which the election is made but would not be earlier than the first day of the month in which the notice of the Medicare entitlement determination is received by the individual.

(11)(i) The individual enrolled in an MA special needs plan (SNP) and is no longer eligible for the SNP because he or she no longer meets the applicable special needs status.

(ii) This SEP begins the month the individual's special needs status changes and ends when the individual makes an enrollment request or 3 calendar months after the effective date of involuntary disenrollment from the SNP, whichever is earlier.

(12) The individual belongs to a qualified State Pharmaceutical Assistance Program (SPAP) and is requesting enrollment in an MA–PD plan.

(i) The individual may make one MA election per year.

(ii) This SEP is available while the individual is enrolled in the SPAP and, upon loss of eligibility for SPAP benefits, for an additional 2 calendar months after either the month of the loss of eligibility or notification of the loss, whichever is later.

(13)(i) The individual has severe or disabling chronic conditions and is eligible to enroll into a Chronic Care SNP designed to serve individuals with those conditions. The SEP is for an enrollment election that is consistent with the individual's eligibility for a Chronic Care SNP. Individuals enrolled in a Chronic Care SNP who have a severe or disabling chronic condition which is not a focus of their current SNP are eligible for this SEP to request enrollment in a Chronic Care SNP that focuses on this other condition. Individuals who are found after enrollment not to have the qualifying condition necessary to be eligible for the Chronic Care SNP are eligible for a SEP to enroll in a different MA plan.

(ii) This SEP is available while the individual has the qualifying condition and ends upon enrollment in the Chronic Care SNP. This SEP begins when the MA organization notifies the individual of the lack of eligibility and extends through the end of that month and the following 2 calendar months. The SEP ends when the individual makes an enrollment election or on the last day of the second of the 2 calendar months following notification of the lack of eligibility, whichever occurs first.

(14) The individual is enrolled in an MA–PD plan and requests to disenroll from that plan to enroll in or maintain other creditable prescription drug coverage.

(i) This SEP is available while the individual is enrolled in an MA–PD plan. The effective date of disenrollment from the MA plan is the first day of the month following the month a disenrollment request is received by the MA organization.

(ii) Permissible enrollment changes during this SEP are to disenroll from an MA–PD plan and elect original Medicare or to elect an MA-only plan, resulting in disenrollment from the MA–PD plan.

(15) The individual is requesting enrollment in an MA plan offered by an MA organization with a Star Rating of 5 Stars. An individual may use this SEP only once for the contract year in which the MA plan was assigned a 5-star overall performance rating, beginning the December 8th before that contract year through November 30th of that contract year.

(16) The individual is a non-U.S. citizen who becomes lawfully present in the United States.

(i) This SEP begins the month the individual attains lawful presence status and ends the earlier of when the individual makes an enrollment election or 2 calendar months after the month the individual attains lawful presence status.

(ii) [Reserved]

(17) The individual was adversely affected by having requested, but not received, required notices or information in an accessible format, as outlined in section 504 of the Rehabilitation Act of 1973 within the same timeframe that the MA organization or CMS provided the same information to individuals who did not request an accessible format.

(i) The SEP begins at the end of the election period during which the individual was seeking to make an enrollment election and the length is at least as long as the time it takes for the information to be provided to the individual in an accessible format.

(ii) MA organizations may determine eligibility for this SEP when the criterion is met, ensuring adequate documentation of the situation, including records indicating the date of the individual's request, the amount of time taken to provide accessible versions of the requested materials and the amount of time it takes for the same information to be provided to an individual who does not request an accessible format.

(18) Individuals affected by an emergency or major disaster declared by a Federal, state or local government entity are eligible for a SEP to make a MA enrollment or disenrollment election. The SEP starts as of the date the declaration is made, the incident start date or, if different, the start date identified in the declaration, whichever is earlier, and ends 2 full calendar months following the end date identified in the declaration or, if different, the date the end of the incident is announced, whichever is later. The individual is eligible for this SEP provided the individual—

(i)(A) Resides, or resided at the start of the SEP eligibility period described in this paragraph (b)(18), in an area for which a federal, state or local government entity has declared an emergency or major disaster; or

(B) Does not reside in an affected area but relies on help making healthcare decisions from one or more individuals who reside in an affected area; and

(ii) Was eligible for another election period at the time of the SEP eligibility period described in this paragraph (b)(18); and

(iii) Did not make an election during that other election period due to the emergency or major disaster.

(19) The individual experiences an involuntary loss of creditable prescription drug coverage, including a reduction in the level of coverage so that it is no longer creditable and excluding any loss or reduction of creditable coverage that is due to a failure to pay premiums.

Back to Agenda Back to Item

(i) The individual is eligible to request enrollment in an MA–PD plan.

(ii) The SEP begins when the individual is notified of the loss of creditable coverage and ends 2 calendar months after the later of the loss (or reduction) or the individual's receipt of the notice.

(iii) The effective date of this SEP is the first of the month after the enrollment election is made or, at the individual's request, may be up to 3 months prospective.

(20) The individual was not adequately informed of a loss of creditable prescription drug coverage, or that they never had creditable coverage. CMS determines eligibility for this SEP on a case-by-case basis, based on its determination that an entity offering prescription drug coverage failed to provide accurate and timely disclosure of the loss of creditable prescription drug coverage or whether the prescription drug coverage offered is creditable.

(i) The individual is eligible for one enrollment in, or disenrollment from, an MA–PD plan.

(ii) This SEP begins the month of CMS' determination and continues for 2 additional calendar months following the determination.

(21) The individual's enrollment or non-enrollment in an MA–PD plan is erroneous due to an action, inaction, or error by a Federal employee.

(i) The individual is permitted enrollment in, or disenrollment from, the MA–PD plan, as determined by CMS.

(ii) This SEP begins the month of CMS approval of this SEP on the basis that the individual's enrollment was erroneous due to an action, inaction, or error by a Federal employee and continues for 2 additional calendar months following this approval.

(22) The individual is eligible for an additional Part D Initial Election Period, such as an individual currently entitled to Medicare due to a disability and who is attaining age 65.

(i) The individual is eligible to make an MA election to coordinate with the additional Part D Initial Election Period.

(ii) The SEP may be used to disenroll from an MA plan, with or without Part D benefits, to enroll in original Medicare, or to enroll in an MA plan that does not include Part D benefits, regardless of whether the individual uses the Part D Initial Election Period to enroll in a PDP.

(iii) The SEP begins and ends concurrently with the additional Part D Initial Election Period.

(23) Individuals affected by a significant change in plan provider network are eligible for a SEP that permits disenrollment from the MA plan that has changed its network to another MA plan or to original Medicare. This SEP can be used only once per significant change in the provider network.

(i) The SEP begins the month the individual is notified of eligibility for the SEP and extends an additional 2 calendar months thereafter.

(ii) An enrollee is affected by a significant network change when the enrollee is assigned to, currently receiving care from, or has received care within the past 3 months from a provider or facility being terminated from the provider network.

(iii) When instructed by CMS, the MA plan that has significantly changed its network must issue a notice, in the form and manner directed by CMS, that notifies enrollees who are eligible for this SEP of their eligibility for the SEP and how to use the SEP.

(24) The individual is enrolled in a plan offered by an MA organization that has been placed into receivership by a state or territorial regulatory authority. The SEP begins the month the receivership is effective and continues until it is no longer in effect or until the enrollee makes an election, whichever occurs first. When instructed by CMS, the MA plan that has been placed under receivership must notify its enrollees, in the form and manner directed by CMS, of the enrollees' eligibility for this SEP and how to use the SEP.

(25) The individual is enrolled in a plan that has been identified with the low performing icon in accordance with § 422.166(h)(1)(ii). This SEP exists while the individual is enrolled in the low performing MA plan.

* * * * *

■ 8. Section 422.68 is amended by revising paragraph (d) to read as follows:

§ 422.68 Effective dates of coverage and change of coverage.

* * * * *

(d) *Special election periods.* For an election or change of election made during a special election period as described in § 422.62(b), the coverage or change in coverage is effective the first day of the calendar month following the month in which the election is made, unless otherwise noted.

* * * * *

■ 10. Section 422.102 is amended by adding paragraph (f) to read as follows:

§ 422.102 Supplemental benefits.

* * * * *

(f) *Special supplemental benefits for the chronically ill (SSBCI)—Requirements*—(i) *Chronically-ill enrollee.* (A) A chronically ill enrollee is an individual enrolled in the MA plan who has one or more comorbid and medically complex chronic conditions that meet all of the following:

(*1*) Is life threatening or significantly limits the overall health or function of the enrollee;

(*2*) Has a high risk of hospitalization of other adverse health outcomes; and

(*3*) Requires intensive care coordination.

(B) CMS may publish a non-exhaustive list of conditions that are medically complex chronic conditions that are life threatening or significantly limit the overall health or function of an individual.

(ii) *SSBCI definition.* A special supplemental benefit for the chronically ill (SSBCI) is a supplemental benefit that has, with respect to a chronically ill enrollee, a reasonable expectation of improving or maintaining the health or overall function of the enrollee; an SSBCI that meets the standard in this paragraph (f)(1)(ii) may also include a benefit that is not primarily health related.

(2) *Offering SSBCI.* (i) An MA plan may offer SSBCI to a chronically ill enrollee only as a mandatory supplemental benefit.

(ii) Upon approval by CMS, an MA plan may offer SSBCI that are not uniform for all chronically ill enrollees in the plan.

(iii) An MA plan may consider social determinants of health as a factor to help identify chronically ill enrollees whose health or overall function could be improved or maintained with SSBCI. An MA plan may not use social determinants of health as the sole basis for determining eligibility for SSBCI.

(3) *Plan responsibilities.* An MA plan offering SSBCI must do all of the following:

(i) Must have written policies for determining enrollee eligibility and must document its determination that an enrollee is a chronically ill enrollee based on the definition in paragraph (f)(1)(i) of this section.

(ii) Make information and documentation related to determining enrollee eligibility available to CMS upon request.

(iii) Must have written policies based on objective criteria for determining a chronically ill enrollee's eligibility to receive a particular SSBCI and must document these criteria.

(iv) Document each determination that an enrollee is eligible to receive an SSBCI and make this information available to CMS upon request.

§ 422.110 [Amended]

■ 11. Section 422.110 is amended in paragraph (b) by removing the phrase ''An MA organization'' and adding in its place the phrase ''For coverage before January 1, 2021, an MA organization''.

■ 12. Section 422.116 is added to read as follows:

§ 422.116 Network adequacy.

(a) *General rules*—(1) *Access.* (i) A network-based MA plan, as described in § 422.114(a)(3)(ii) but not including MSA plans, must demonstrate that it has an adequate contracted provider network that is sufficient to provide access to covered services in accordance with access standards described in section 1852(d)(1) of the Act and in §§ 422.112(a) and 422.114(a)(1) and by meeting the standard in paragraph (a)(2) of this section. When required by CMS, an MA organization must attest that it has an adequate network for access and availability of a specific provider or facility type that CMS does not independently evaluate in a given year.

(ii) CMS does not require information, other than an attestation, regarding compliance with § 422.116 as part of an application for a new or expanding service area and will not deny application on the basis of an evaluation of the applicant's network for the new or expanding service area.

(2) *Standards.* An MA plan must meet maximum time and distance standards and contract with a specified minimum number of each provider and facility-specialty type.

(i) Each contract provider type must be within maximum time and distance of at least one beneficiary (in the MA Medicare Sample Census) in order to count toward the minimum number.

(ii) The minimum number criteria and the time and distance criteria vary by the county type.

(3) *Applicability of MA network adequacy criteria.* (i) The following providers and facility types do not count toward meeting network adequacy criteria:

(A) Specialized, long-term care, and pediatric/children's hospitals.

(B) Providers that are only available in a residential facility.

(C) Providers and facilities contracted with the organization only for its commercial, Medicaid, or other products.

(ii) [Reserved]

(4) *Annual updates by CMS.* CMS annually updates and makes the following available:

(i) A Health Service Delivery (HSD) Reference file that identifies the following:

(A) All minimum provider and facility number requirements.

(B) All provider and facility time and distance standards.

(C) Ratios established in paragraph (e) of this section in advance of network reviews for the applicable year.

(ii) A Provider Supply file that lists available providers and facilities and their corresponding office locations and specialty types.

(A) The Provider Supply file is updated annually based on information in the Integrated Data Repository (IDR), which has comprehensive claims data, and information from public sources.

(B) CMS may also update the Provider Supply file based on findings from validation of provider information submitted on Exception Requests to reflect changes in the supply of health care providers and facilities.

(b) *Provider and facility-specialty types.* The provider and facility-specialty types to which the network adequacy evaluation under this section applies are specified in this paragraph (b).

(1) *Provider-specialty types.* The provider-specialty types are as follows:

(i) Primary Care.
(ii) Allergy and Immunology.
(iii) Cardiology.
(iv) Chiropractor.
(v) Dermatology.
(vi) Endocrinology.
(vii) ENT/Otolaryngology.
(viii) Gastroenterology.
(ix) General Surgery.
(x) Gynecology, OB/GYN.
(xi) Infectious Diseases.
(xii) Nephrology.
(xiii) Neurology.
(xiv) Neurosurgery.
(xv) Oncology—Medical, Surgical.
(xvi) Oncology—Radiation/Radiation Oncology.
(xvii) Ophthalmology.
(xviii) Orthopedic Surgery.
(xix) Physiatry, Rehabilitative Medicine.
(xx) Plastic Surgery.
(xxi) Podiatry.
(xxii) Psychiatry.
(xxiii) Pulmonology.
(xxiv) Rheumatology.
(xxv) Urology.
(xxvi) Vascular Surgery.
(xxvii) Cardiothoracic Surgery.

(2) *Facility-specialty types.* The facility specialty types are as follows:

(i) Acute Inpatient Hospitals.
(ii) Cardiac Surgery Program.
(iii) Cardiac Catheterization Services.
(iv) Critical Care Services—Intensive Care Units (ICU).
(v) Surgical Services (Outpatient or ASC).
(vi) Skilled Nursing Facilities.
(vii) Diagnostic Radiology.
(viii) Mammography.
(ix) Physical Therapy.
(x) Occupational Therapy.
(xi) Speech Therapy.
(xii) Inpatient Psychiatric Facility Services.
(xiii) Outpatient Infusion/Chemotherapy.

(3) *Removal of a provider or facility-specialty type.* CMS may remove a specialty or facility type from the network adequacy evaluation for a particular year by not including the type in the annual publication of the HSD reference file.

(c) *County type designations.* Counties are designated as a specific type using the following population size and density parameters:

(1) *Large metro.* A large metro designation is assigned to any of the following combinations of population sizes and density parameters:

(i) A population size greater than or equal to 1,000,000 persons with a population density greater than or equal to 1,000 persons per square mile.

(ii) A population size greater than or equal to 500,000 and less than or equal to 999,999 persons with a population density greater than or equal to 1,500 persons per square mile.

(iii) Any population size with a population density of greater than or equal to 5,000 persons per square mile.

(2) *Metro.* A metro designation is assigned to any of the following combinations of population sizes and density parameters:

(i) A population size greater than or equal to 1,000,000 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 999.9 persons per square mile.

(ii) A population size greater than or equal to 500,000 persons and less than or equal to 999,999 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 1,499.9 persons per square mile.

(iii) A population size greater than or equal to 200,000 persons and less than or equal to 499,999 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 4,999.9 persons per square mile.

(iv) A population size greater than or equal to 50,000 persons and less than or equal to 199,999 persons with a population density greater than or equal to 100 persons per square mile and less than or equal to 4999.9 persons per square mile.

(v) A population size greater than or equal to 10,000 persons and less than or

equal to 49,999 persons with a population density greater than or equal to 1,000 persons per square mile and less than or equal to 4999.9 persons per square mile.

(3) *Micro.* A micro designation is assigned to any of the following combinations of population sizes and density parameters:

(i) A population size greater than or equal to 50,000 persons and less than or equal to 199,999 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 99.9 persons per square mile.

(ii) A population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density greater than or equal to 50 persons per square mile and less than 999.9 persons per square mile.

(4) *Rural.* A rural designation is assigned to any of the following combinations of population sizes and density parameters:

(i) A population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density of greater than or equal to 10 persons per square mile and less than or equal to 49.9 persons per square mile.

(ii) A population size less than 10,000 persons with a population density greater than or equal 50 persons per square mile and less than or equal to 999.9 persons per square mile.

(5) *Counties with extreme access considerations (CEAC).* For any population size with a population density of less than 10 persons per square mile.

(d) *Maximum time and distance standards*—(1) *General rule.* CMS determines and annually publishes maximum time and distance standards for each combination of provider or facility specialty type and each county type in accordance with paragraphs (d)(2) and (3) of this section.

(i) Time and distance metrics measure the relationship between the approximate locations of beneficiaries and the locations of the network providers and facilities.

(ii) [Reserved]

(2) *By county designation.* The following base maximum time (in minutes) and distance (in miles) standards apply for each county type designation, unless modified through customization as described in paragraph (d)(3) of this section.

TABLE 1 TO PARAGRAPH (d)(2)

Provider/Facility type	Large metro		Metro		Micro		Rural		CEAC	
	Max time	Max distance	Max time	Max distance	Max time	Max distance	Max time	Max distance	Max time	Max distance
Primary Care	10	5	15	10	30	20	40	30	70	60
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Chiropractor	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngology	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynecology, OB/GYN	30	15	45	30	80	60	90	75	125	110
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Neurosurgery	30	15	60	40	100	75	110	90	145	130
Oncology—Medical, Surgical	20	10	45	30	60	45	75	60	110	100
Oncology—Radiation/Radiation Oncology	30	15	60	40	100	75	110	90	145	130
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85
Physiatry, Rehabilitative Medicine	30	15	45	30	80	60	90	75	125	110
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Podiatry	20	10	45	30	60	45	75	60	110	100
Psychiatry	20	10	45	30	60	45	75	60	110	100
Pulmonology	20	10	45	30	60	45	75	60	110	100
Rheumatology	30	15	60	40	100	75	110	90	145	130
Urology	20	10	45	30	60	45	75	60	110	100
Vascular Surgery	30	15	60	40	100	75	110	90	145	130
Cardiothoracic Surgery	30	15	60	40	100	75	110	90	145	130
Acute Inpatient Hospitals	20	10	45	30	80	60	75	60	110	100
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140
Critical Care Services—Intensive Care Units (ICU)	20	10	45	30	160	120	145	120	155	140
Surgical Services (Outpatient or ASC)	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Diagnostic Radiology	20	10	45	30	80	60	75	60	110	100
Mammography	20	10	45	30	80	60	75	60	110	100
Physical Therapy	20	10	45	30	80	60	75	60	110	100
Occupational Therapy	20	10	45	30	80	60	75	60	110	100
Speech Therapy	20	10	45	30	80	60	75	60	110	100
Inpatient Psychiatric Facility Services	30	15	70	45	100	75	90	75	155	140
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60	75	60	110	100

Back to Agenda Back to Item

(3) *By customization.* When necessary due to utilization or supply patterns, CMS may set maximum time and distance standards for provider or facility types for specific counties by customization in accordance with the following rules:

(i) CMS maps provider location data from the Provider Supply file against its MA Medicare Sample Census (which provides MA enrollee population distribution data) or uses claims data to identify the distances beneficiaries travel according to the usual patterns of care for the county.

(ii) CMS identifies the distance at which 90 percent of the population would have access to at least one provider or facility in the applicable specialty type.

(iii) The resulting distance is then rounded up to the next multiple of 5, and a multiplier specific to the county designation is applied to determine the analogous maximum time.

(iv) Customization may only be used to increase the base time and distance standards specified in paragraph (d)(2) of this section and may not be used to decrease the base time and distance standards.

(4) *Percentage of beneficiaries residing within maximum time and distance standards.* MA plans must ensure both of the following:

(i) At least 85 percent of the beneficiaries residing in micro, rural, or CEAC counties have access to at least one provider/facility of each specialty type within the published time and distance standards.

(ii) At least 90 percent of the beneficiaries residing in large metro and metro counties have access to at least one provider/facility of each specialty type within the published time and distance standards.

(5) *MA telehealth providers.* An MA plan receives a 10 percentage point credit towards the percentage of beneficiaries residing within published time and distance standards for the applicable provider specialty type and county when the plan includes one or more telehealth providers that provide additional telehealth benefits, as defined in § 422.135, in its contracted networks for the following provider specialty types:

(i) Dermatology.
(ii) Psychiatry.
(iii) Cardiology.
(iv) Neurology.
(v) Otolaryngology.
(vi) Ophthalmology.
(vii) Allergy and Immunology.
(viii) Nephrology.
(ix) Primary Care.
(x) Gynecology/OB/GYN.
(xi) Endocrinology.
(xii) Infectious Diseases.

(6) *State Certificate of Need (CON) laws.* In a State with CON laws, or other state imposed anti-competitive restrictions that limit the number of providers or facilities in the State or a county in the State, CMS will award the MA organization a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards for affected providers and facilities in paragraph (b) of this section or, when necessary due to utilization or supply patterns, customize the base time and distance standards.

(e) *Minimum number standard.* CMS annually determines the minimum number standard for each provider and facility-specialty type as follows:

(1) *General rule.* The provider or facility must—

(i) Be within the maximum time and distance of at least one beneficiary in order to count towards the minimum number standard (requirement); and

(ii) Not be a telehealth-only provider.

(2) *Minimum number requirement for provider and facility-specialty types.* The minimum number for provider and facility-specialty types are as follows:

(i) For provider-specialty types described in paragraph (b)(1) of this section, CMS calculates the minimum number as specified in paragraph (e)(3) of this section.

(ii) For facility-specialty types described in paragraph (b)(2)(i) of this section, CMS calculates the minimum number as specified in paragraph (e)(3) of this section.

(iii) For facility-specialty types described in paragraphs (b)(2)(ii) through (xiv) of this section, the minimum requirement number is 1.

(3) *Determination of the minimum number of for certain provider and facility-specialty types.* For specialty types in paragraphs (b)(1) and (b)(2)(i) of this section, CMS multiplies the minimum ratio by the number of beneficiaries required to cover, divides the resulting product by 1,000, and rounds it up to the next whole number.

(i)(A) The minimum ratio for provider specialty types represents the minimum number of providers per 1,000 beneficiaries.

(B) The minimum ratio for facility specialty type specified in paragraph (b)(2)(i) of this section (acute inpatient hospital) represents the minimum number of beds per 1,000 beneficiaries.

(C) The minimum ratios are as follows:

TABLE 2 TO PARAGRAPH (E)(3)(I)(C)

Minimum ratio	Large metro	Metro	Micro	Rural	CEAC
Primary Care	1.67	1.67	1.42	1.42	1.42
Allergy and Immunology	0.05	0.05	0.04	0.04	0.04
Cardiology	0.27	0.27	0.23	0.23	0.23
Chiropractor	0.10	0.10	0.09	0.09	0.09
Dermatology	0.16	0.16	0.14	0.14	0.14
Endocrinology	0.04	0.04	0.03	0.03	0.03
ENT/Otolaryngology	0.06	0.06	0.05	0.05	0.05
Gastroenterology	0.12	0.12	0.10	0.10	0.10
General Surgery	0.28	0.28	0.24	0.24	0.24
Gynecology, OB/GYN	0.04	0.04	0.03	0.03	0.03
Infectious Diseases	0.03	0.03	0.03	0.03	0.03
Nephrology	0.09	0.09	0.08	0.08	0.08
Neurology	0.12	0.12	0.10	0.10	0.10
Neurosurgery	0.01	0.01	0.01	0.01	0.01
Oncology—Medical, Surgical	0.19	0.19	0.16	0.16	0.16
Oncology—Radiation/Radiation Oncology	0.06	0.06	0.05	0.05	0.05
Ophthalmology	0.24	0.24	0.20	0.20	0.20
Orthopedic Surgery	0.20	0.20	0.17	0.17	0.17
Physiatry, Rehabilitative Medicine	0.04	0.04	0.03	0.03	0.03
Plastic Surgery	0.01	0.01	0.01	0.01	0.01
Podiatry	0.19	0.19	0.16	0.16	0.16

Back to Agenda Back to Item

TABLE 2 TO PARAGRAPH (E)(3)(i)(C)—Continued

Minimum ratio	Large metro	Metro	Micro	Rural	CEAC
Psychiatry	0.14	0.14	0.12	0.12	0.12
Pulmonology	0.13	0.13	0.11	0.11	0.11
Rheumatology	0.07	0.07	0.06	0.06	0.06
Urology	0.12	0.12	0.10	0.10	0.10
Vascular Surgery	0.02	0.02	0.02	0.02	0.02
Cardiothoracic Surgery	0.01	0.01	0.01	0.01	0.01
Acute Inpatient Hospitals	12.2	12.2	12.2	12.2	12.2

(ii)(A) *Number of beneficiaries required to cover.* (*1*) The number of beneficiaries required to cover is calculated by multiplying the 95th percentile base population ratio by the total number of Medicare beneficiaries residing in a county.

(*2*) CMS uses its MA State/County Penetration data to calculate the total number of beneficiaries residing in a county.

(B) *95th percentile base population ratio.* (*1*) The 95th percentile base population ratio is:

(*i*) Calculated annually for each county type and varies over time as MA market penetration and plan enrollment change across markets; and

(*ii*) Represents the proportion of Medicare beneficiaries enrolled in the 95th percentile MA plan (that is, 95 percent of plans have enrollment lower than this level).

(*2*) CMS calculates the 95th percentile base population ratio as follows:

(*i*) Uses its most recent List of PFFS Network Counties to exclude any private-fee-for-service (PFFS) plans in non-networked counties from the calculation at the county-type level.

(*ii*) Uses its most recent MA State/County Penetration data to determine the number of eligible Medicare beneficiaries in each county.

(*iii*) Uses its Monthly MA Enrollment By State/County/Contract data to determine enrollment at the contract ID and county level, including only enrollment in regional preferred provider organization (RPPO), local preferred provider organization (LPPO), HMO, HMO/provider sponsored organization (POS), healthcare prepayment plans under section 1833 of the Act, and network PFFS plan types.

(*iv*) Calculates penetration at the contract ID and county level by dividing the number of enrollees for a given contract ID and county by the number of eligible beneficiaries in that county.

(*v*) Groups counties by county designation to determine the 95th percentile of penetration among MA plans for each county type.

(f) *Exception requests.* (1) An MA plan may request an exception to network adequacy criteria in paragraphs (b) through (e) of this section when both of the following occur:

(i) Certain providers or facilities are not available for the MA plan to meet the network adequacy criteria as shown in the Provider Supply file for the year for a given county and specialty type.

(ii) The MA plan has contracted with other providers and facilities that may be located beyond the limits in the time and distance criteria, but are currently available and accessible to most enrollees, consistent with the local pattern of care.

(2) In evaluating exception requests, CMS considers whether—

(i) The current access to providers and facilities is different from the HSD reference and Provider Supply files for the year;

(ii) There are other factors present, in accordance with § 422.112(a)(10)(v), that demonstrate that network access is consistent with or better than the original Medicare pattern of care; and

(iii) Approval of the exception is in the best interests of beneficiaries.

■ 13. Section 422.162 is amended in paragraph (a) by adding a definition for ''Tukey outer fence outliers'' in alphabetical order to read as follows:

§ 422.162 Medicare Advantage Quality Rating System.

(a) * * *

Tukey outer fence outliers are measure scores that are below a certain point (first quartile − 3.0 × (third quartile − first quartile)) or above a certain point (third quartile + 3.0 × (third quartile − first quartile)).

* * * * *

■ 14. Section 422.166 is amended—

■ a. By revising paragraph (a)(2)(i); and

■ b. In paragraphs (e)(1)(iii) and (iv) by removing the phrase ''weight of 2'' and adding in its place ''weight of 4''.

The revision reads as follows:

§ 422.166 Calculation of Star Ratings.

(a) * * *

(2) * * *

(i) The method maximizes differences across the star categories and minimizes the differences within star categories using mean resampling with the hierarchal clustering of the current year's data. Effective for the Star Ratings issued in October 2022 and subsequent years, CMS will add a guardrail so that the measure-threshold-specific cut points for non-CAHPS measures do not increase or decrease more than the value of the cap from 1 year to the next. Effective for the Star Ratings issued in October 2023 and subsequent years, prior to applying mean resampling with hierarchal clustering, Tukey outer fence outliers are removed. The cap is equal to 5 percentage points for measures having a 0 to 100 scale (absolute percentage cap) or 5 percent of the restricted range for measures not having a 0 to 100 scale (restricted range cap). New measures that have been in the Part C and D Star Rating program for 3 years or less use the hierarchal clustering methodology with mean resampling with no guardrail for the first 3 years in the program.

* * * * *

§ 422.258 [Amended]

■ 15. Section 422.258 is amended in paragraphs (d)(3), (d)(5) introductory text, (d)(5)(i) introductory text, (d)(5)(ii), and (d)(6)(i) by removing the reference ''§ 422.306(c)'' and adding in its place the reference '' § 422.306(c) and (d)''.

165. Section 422.306 is amended—

■ a. In the introductory text by:

■ i. Removing ''§§ 422.308(b) and 422.308(g)'' and adding in its place ''§ 422.308(b) and (g)''; and

■ ii. Removing the phrase ''year under paragraph (c) of this section'' and adding in its place the phrase ''year under paragraph (c) of this section and costs for kidney acquisitions in the area for the year under paragraph (d) of this section''; and

■ b. By adding paragraph (d).

The addition reads as follows:

§ 422.306 Annual MA capitation rates.

* * * * *

(d) *Exclusion of costs for kidney acquisitions from MA capitation rates.* Beginning with 2021, after the annual capitation rate for each MA local area is determined under paragraph (a) or (b) of

this section, the amount is adjusted in accordance with section 1853(k)(5) of the Act to exclude the Secretary's estimate of the standardized costs for payments for organ acquisitions for kidney transplants covered under this title (including expenses covered under section 1881(d) of the Act) in the area for the year.

§ 422.312 [Amended]

■ 17. Section 422.312 is amended—
■ a. In paragraph (b)(1) by removing the phrase ''45 days'' and adding in its place the phrase ''60 days''; and
■ b. In paragraph (b)(2) by removing the phrase ''15 days'' and adding in its place the phrase ''30 days''.

■ 18. Section 422.322 is amended by adding paragraph (d) to read as follows:

§ 422.322 Source of payment and effect of MA plan election on payment.

* * * * *

(d) *FFS payment for expenses for kidney acquisitions.* Paragraphs (b) and (c) of this section do not apply with respect to expenses for organ acquisitions for kidney transplants described in section 1852(a)(1)(B)(i) of the Act.

■ 19. Section 422.514 is amended by—
■ a. Revising the section heading and the heading for paragraph (a).
■ b. Adding paragraphs (d), (e), and (f).

The revisions and additions read as follows:

§ 422.514 Enrollment requirements.

(a) *Minimum enrollment rules.* * * *

* * * * *

(d) *Rule on dual eligible enrollment.* In any state where there is a dual eligible special needs plan or any other plan authorized by CMS to exclusively enroll individuals entitled to medical assistance under a state plan under title XIX, CMS does not:

(1) Enter into a contract under this subpart, for plan year 2022 and subsequent years, for a new MA plan that—

(i) Is not a specialized MA plan for special needs individuals as defined in § 422.2; and

(ii) Projects enrollment in its bid submitted under § 422.254 that 80 percent or more enrollees of the plan's total enrollment are enrollees entitled to medical assistance under a state plan under title XIX.

(2) Renew a contract under this subpart, for plan year 2023 and subsequent years, for an MA plan that—

(i) Is not a specialized MA plan for special needs individuals as defined in § 422.2; and

(ii) Has actual enrollment, as determined by CMS using the January enrollment of the current year, consisting of 80 percent or more of enrollees who are entitled to medical assistance under a state plan under title XIX, unless the MA plan has been active for less than 1 year and has enrollment of 200 or fewer individuals at the time of such determination.

(e) *Transition process and procedures.* (1) For coverage effective January 1 of the next year, and subject to the disclosure requirements described in paragraph (e)(2) of this section, an MA organization may transition enrollees in a plan specified in paragraph (d)(2) of this section into another MA plan or plans (including into a dual eligible special needs plan for enrollees who are eligible for such a plan) offered by the MA organization, or another MA organization that shares the same parent organization as the MA organization, for which the individual is eligible in accordance with §§ 422.50 through 422.53 if the MA plan or plans receiving such enrollment—

(i) Would not meet the criteria in paragraph (d)(2)(ii) of this section, as determined in the procedures described in paragraph (e)(3) of this section, with the addition of the newly enrolled individuals (unless such plan is a Specialized MA plan for Special Needs Individuals as defined in § 422.2);

(ii) Is an MA–PD plan described at § 422.2;

(iii) Has a combined Part C and Part D premium of $0.00 for individuals eligible for the premium subsidy for full subsidy eligible individuals described in § 423.780(a) of this chapter; and

(iv) Is of the same plan type (for example, HMO or PPO) as the plan specified in paragraph (d)(2) of this section.

(2) An MA organization may transition individuals under paragraph (e)(1) of this section without requiring the individual to file the election form under § 422.66(a) if—

(i) The enrolled individual is eligible to enroll in the MA plan; and

(ii) The MA–PD plan into which individuals are transitioned describes changes to MA–PD benefits and provides information about the MA–PD plan in the Annual Notice of Change, which must be sent consistent with § 422.111(a), (d), and (e).

(3) For the purpose of approving a MA organization to transition enrollment under this paragraph (e), CMS determines whether a non-SNP MA plan would meet the criteria in paragraph (d)(2) of this section by adding the cohort of individuals identified by the MA organization for enrollment in a non-SNP MA plan to the April enrollment of such plan and calculating the resulting percentage of dual eligible enrollment.

(4) In cases where an MA organization does not transition current enrollees under paragraph (e)(1) of this section, the MA organization must send a written notice to enrollees who are not transitioned, consistent with § 422.506(a)(2).

(f) *Special considerations.* Actions taken pursuant to paragraph (d) of this section warrant special consideration to exempt affected MA organizations from the denial of an application for a new contract or service area expansion in accordance with §§ 422.502(b)(3) and (4), 422.503(b)(6) and (7), 422.506(a)(3) and (4), 422.508(c) and (d), and 422.512(e)(1) and (2).

■ 20. Section 422.2420 is amended by revising paragraph (b)(2)(i) to read as follows:

§ 422.2420 Calculation of the medical loss ratio.

* * * * *

(b) * * *

(2) * * *

(i) Amounts that the MA organization pays (including under capitation contracts) for covered services, described at paragraph (a)(2) of this section, provided to all enrollees under the contract.

* * * * *

■ 21. Section 422.2440 is revised to read as follows:

§ 422.2440 Credibility adjustment.

(a) An MA organization may add the credibility adjustment specified under paragraph (e) of this section to a contract's MLR if the contract's experience is partially credible, as defined in paragraph (d)(1) of this section.

(b) An MA organization may not add a credibility adjustment to a contract's MLR if the contract's experience is fully credible, as defined in paragraph (d)(2) of this section.

(c) For those contract years for which a contract has non-credible experience, as defined in paragraph (d)(3) of this section, sanctions under § 422.2410(b) through (d) will not apply.

(d)(1) A contract's experience is partially credible if it is based on the experience of at least 2,400 member months and fewer than or equal to 180,000 member months.

(2) A contract's experience is fully credible if it is based on the experience of more than 180,000 member months.

(3) A contract's experience is non-credible if it is based on the experience of fewer than 2,400 member months.

(e)(1) The credibility adjustment for a partially credible MA contract, other

than an MSA contract, is equal to the base credibility factor determined under paragraph (f) of this section.

(2) The credibility adjustment for a partially credible MA MSA contract is the product of the base credibility factor, as determined under paragraph (f) of this section, multiplied by the deductible factor, as determined under paragraph (g) of this section.

(f) The base credibility factor for partially credible experience is determined based on the number of member months for all enrollees under the contract and the factors shown in Table 1 of this section. When the number of member months used to determine credibility exactly matches a member month category listed in Table 1 of this section, the value associated with that number of member months is the base credibility factor. The base credibility factor for a number of member months between the values shown in Table 1 of this section is determined by linear interpolation.

(g) The deductible factor is based on the enrollment-weighted average deductible for all MSA plans under the MA MSA contract, where the deductible for each plan under the contract is weighted by the plan's portion of the total number of member months for all plans under the contract. When the weighted average deductible exactly matches a deductible category listed in Table 2 of this section, the value associated with that deductible is the deductible factor. The deductible factor for a weighted average deductible between the values shown in Table 2 of section is determined by linear interpolation.

TABLE 1 TO § 422.2440—BASE CREDIBILITY FACTORS FOR MA CONTRACTS

Member months	Base credibility factor (additional percentage points)
<2,400	N/A (Non-credible).
2,400	8.4%.
6,000	5.3%.
12,000	3.7%.
24,000	2.6%.
60,000	1.7%.
120,000	1.2%.
180,000	1.0%.
>180,000	0.0% (Fully credible).

TABLE 2 TO § 422.2440—DEDUCTIBLE FACTORS FOR MA MSA CONTRACTS

Weighted average deductible	Deductible factor
<$2,500	1.000
$2,500	1.164
$5,000	1.402
≥$10,000	1.736

PART 423—VOLUNTARY MEDICARE PRESCRIPTION DRUG BENEFIT

■ 22. The authority citation for part 423 continues to read as follows:

Authority: 42 U.S.C. 1302, 1306, 1395w–101 through 1395w–152, and 1395hh.

■ 23. Section 423.38 is amended by revising paragraph (c)(8) and adding paragraphs (c)(11) through (34) to read as follows:

§ 423.38 Enrollment periods.

* * * * *

(c) * * *

(8) The individual demonstrates to CMS, in accordance with guidelines issued by CMS, that the PDP sponsor offering the PDP substantially violated a material provision of its contract under this part in relation to the individual, including, but not limited to any of the following:

(i) Failure to provide the individual on a timely basis benefits available under the plan.

(ii) Failure to provide benefits in accordance with applicable quality standards.

(iii) The PDP (or its agent, representative, or plan provider) materially misrepresented the plan's provisions in communications as outlined in subpart V of this part.

* * * * *

(11) The individual is making an enrollment request into or out of an employer sponsored Part D plan, is disenrolling from a Part D plan to take employer sponsored coverage of any kind, or is disenrolling from employer sponsored coverage (including Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage) to elect a Part D plan.

(i) This special election period (SEP) is available to individuals who have (or are enrolling in) an employer or union sponsored Part D plan and ends 2 months after the month the employer or union coverage of any type ends.

(ii) The individual may choose an effective date that is not earlier than the first of the month following the month in which the election is made and no later than up to 3 months after the month in which the election is made.

(12) The individual is enrolled in a Part D plan offered by a Part D plan sponsor that has been sanctioned by CMS and elects to disenroll from that plan in connection with the matter(s) that gave rise to that sanction.

(i) Consistent with the disclosure requirements at § 423.128(f), CMS may require the sponsor to notify current enrollees that if the enrollees believe they are affected by the matter(s) that gave rise to the sanction, the enrollees are eligible for a SEP to elect another PDP.

(ii) The SEP starts with the imposition of the sanction and ends when the sanction ends or when the individual makes an election, whichever occurs first.

(13) The individual is enrolled in a section 1876 cost contract that is non-renewing its contract for the area in which the enrollee resides.

(i) Individuals eligible for this SEP must meet Part D plan eligibility requirements.

(ii) This SEP begins December 8 of the then-current contract year and ends on the last day of February of the following year.

(14) The individual is disenrolling from a PDP to enroll in a Program of All-inclusive Care for the Elderly (PACE) organization or is enrolling in a PDP after disenrolling from a PACE organization.

(i) An individual who disenrolls from PACE has a SEP for 2 months after the effective date of PACE disenrollment to elect a PDP.

(ii) An individual who disenrolls from a PDP has a SEP for 2 months after the effective date of PDP disenrollment to elect a PACE plan.

(15) The individual moves into, resides in, or moves out of an institution, as defined by CMS, and elects to enroll in, or disenroll from, a Part D plan.

(16) The individual is not entitled to premium free Part A and enrolls in Part B during the General Enrollment Period for Part B (January through March) for an effective date of July 1st are eligible to request enrollment in a Part D plan that begins April 1st and ends June 30th, with a Part D plan enrollment effective date of July 1st.

(17) The individual belongs to a qualified State Pharmaceutical Assistance Program (SPAP) and is requesting enrollment in a Part D plan.

(i) The individual is eligible to make one enrollment election per year.

(ii) This SEP is available while the individual is enrolled in the SPAP and, upon loss of eligibility for SPAP benefits, for an additional 2 calendar months after either the month of the loss of eligibility or notification of the loss, whichever is later.

Back to Agenda Back to Item

(18) The individual is enrolled in a Part D plan and elects to disenroll from that Part D plan to enroll in or maintain other creditable prescription drug coverage.

(19)(i) The individual is enrolled in a section 1876 cost contract and an optional supplemental Part D benefit under that contract and elects a Part D plan upon disenrolling from the cost contract.

(ii) The SEP begins the month the individual requests disenrollment from the cost contract and ends when the individual makes an enrollment election or on the last day of the second month following the month the cost contract enrollment ended, whichever is earlier.

(20) The individual is requesting enrollment in a Part D plan offered by a Part D plan sponsor with a Star Rating of 5 Stars. An individual may use this SEP only once for the contract year in which the Part D plan was assigned a 5-star overall performance rating, beginning the December 8 before that contract year through November 30 of that contract year.

(21)(i) The individual is a non-U.S. citizen who becomes lawfully present in the United States.

(ii) This SEP begins the month the enrollee attains lawful presence status and ends the earlier of when the individual makes an enrollment election or 2 calendar months after the month the enrollee attains lawful presence status.

(22) The individual was adversely affected by having requested, but not received, required notices or information in an accessible format, as outlined in section 504 of the Rehabilitation Act of 1973, within the same timeframe that the Part D plan sponsor or CMS provided the same information to individuals who did not request an accessible format.

(i) The SEP begins at the end of the election period during which the individual was seeking to make an election and the length is at least as long as the time it takes for the information to be provided to the individual in an accessible format.

(ii) Part D plan sponsors may determine eligibility for this SEP when the criterion is met, ensuring adequate documentation of the situation, including records indicating the date of the individual's request, the amount of time taken to provide accessible versions of materials and the amount of time it takes for the same information to be provided to an individual who does not request an accessible format.

(23) Individuals affected by an emergency or major disaster declared by a federal, state or local government entity are eligible for a SEP to make a Part D enrollment or disenrollment election. The SEP starts as of the date the declaration is made, the incident start date or, if different, the start date identified in the declaration, whichever is earlier, and ends 2 full calendar months following the end date identified in the declaration or, if different, the date the end of the incident is announced, whichever is later. The individual is eligible for this SEP provided the individual—

(i)(A) Resides, or resided at the start of the SEP eligibility period described in this paragraph (c)(23), in an area for which a Federal, state or local government entity has declared an emergency or major disaster; or

(B) Does not reside in an affected area but relies on help making healthcare decisions from one or more individuals who reside in an affected area;

(ii) Was eligible for another election period at the time of SEP eligibility period described in this paragraph (c)(23); and

(iii) Did not make an election during that other election period due to the emergency or major disaster.

(24) The individual is using the SEP at § 422.62(b)(8) of this chapter to disenroll from a MA plan that includes Part D benefits.

(i) This SEP permits a one-time election to enroll in a Part D plan.

(ii) This SEP begins upon disenrollment from the MA plan and continues for 2 calendar months.

(25)(i) An individual using the MA Open Enrollment Period for Institutionalized Individuals (OEPI) to disenroll from a MA plan that includes Part D benefits plan is eligible for a SEP to request enrollment in a Part D plan.

(ii) The SEP begins with the month the individual requests disenrollment from the MA plan and ends on the last day of the second month following the month MA enrollment ended.

(26) An individual using the Medicare Advantage Open Enrollment Period (MA OEP) to elect original Medicare is eligible for a SEP to make a Part D enrollment election.

(27)(i) The individual is enrolled in a MA special needs plan (SNP) and is no longer eligible for the SNP because he or she no longer meets the specific special needs status.

(ii) The individual may request enrollment in a Part D plan that begins the month the individual's special needs status changes and ends the earlier of when he or she makes an election or 3 months after the effective date of involuntary disenrollment from the SNP.

(28) The individual is found, after enrollment into a Chronic Care SNP, not to have the required qualifying condition.

(i) This individual is eligible to enroll prospectively in a Part D plan.

(ii) This SEP begins when the MA organization notifies the individual of the lack of eligibility for the Chronic Care SNP and extends through the end of that month and the following 2 calendar months.

(iii) The SEP ends when the individual makes an enrollment election or on the last day of the second of the 2 calendar months following notification of the lack of eligibility, whichever occurs first.

(29) The individual uses the SEP at § 422.62(b)(15) of this chapter to enroll in a MA Private Fee-for-Service plan without Part D benefits, or enrolls in a section 1876 cost plan, is eligible to request enrollment in a PDP or the cost plan's optional supplemental Part D benefit, if offered.

(i) This SEP begins the month the individual uses the SEP at § 422.62(b)(15) of this chapter and continues for 2 additional months.

(ii) [Reserved]

(30) An individual who uses the SEP at § 422.62(b)(23) of this chapter to disenroll from a MA plan is eligible to request enrollment in a PDP.

(i) This SEP begins the month the individual is notified of eligibility for the SEP at § 422.62(b)(23) of this chapter and continues for an additional 2 calendar months.

(ii) This SEP permits one enrollment into a PDP.

(iii) This SEP ends when the individual has enrolled in the PDP.

(iv) An individual may use this SEP to request enrollment in a PDP subsequent to having submitted a disenrollment to the MA plan or may simply request enrollment in the PDP, resulting in automatic disenrollment from the MA plan.

(31) The individual is enrolled in a plan offered by a Part D plan sponsor that has been placed into receivership by a state or territorial regulatory authority. The SEP begins the month the receivership is effective and continues until it is no longer in effect or until the enrollee makes an election, whichever occurs first. When instructed by CMS, the MA plan that has been placed under receivership must notify its enrollees, in the form and manner directed by CMS, of the enrollees' eligibility for this SEP and how to use the SEP.

(32) The individual is enrolled in a plan that has been identified with the low performing icon in accordance with § 423.186(h)(1)(ii). This SEP exists while

the individual is enrolled in the low performing Part D plan.

(33) The individual was involuntarily disenrolled from an MA–PD plan due to loss of Part B but continues to be entitled to Part A. This SEP begins when the individual is advised of the loss of Part B and continues for 2 additional months.

(34) The individual meets other exceptional circumstances as CMS may provide.

* * * * *

■ 24. Section 423.40 is amended by revising paragraph (c) to read as follows:

§ 423.40 Effective dates.

* * * * *

(c) *Special enrollment periods.* For an enrollment or change of enrollment in Part D made during a special enrollment period specified in § 423.38(c), the coverage or change in coverage is effective the first day of the calendar month following the month in which the election is made, unless otherwise noted.

* * * * *

■ 25. Section 423.182 is amended in paragraph (a) by adding a definition for ''Tukey outer fence outliers'' in alphabetical order to read as follows:

§ 423.182 Part D Prescription Drug Plan Quality Rating System.

(a) * * *

Tukey outer fence outliers are measure scores that are below a certain point (first quartile − 3.0 × (third quartile − first quartile)) or above a certain point (third quartile + 3.0 × (third quartile − first quartile)).

* * * * *

■ 26. Section 423.186 is amended—

■ a. By revising paragraph (a)(2)(i); and

■ b. In paragraphs (e)(1)(iii) and (iv) by removing the phrase ''weight of 2'' and adding in its place ''weight of 4''.

The revision reads as follows:

§ 423.186 Calculation of Star Ratings.

(a) * * *

(2) * * *

(i) The method maximizes differences across the star categories and minimizes the differences within star categories using mean resampling with the hierarchal clustering of the current year's data. Effective for the Star Ratings issued in October 2022 and subsequent years, CMS will add a guardrail so that the measure-threshold-specific cut points for non-CAHPS measures do not increase or decrease more than the value of the cap from one year to the next. Effective for the Star Ratings issued in October 2023 and subsequent years, prior to applying mean resampling with hierarchal clustering, Tukey outer fence outliers are removed. The cap is equal to 5 percentage points for measures having a 0 to 100 scale (absolute percentage cap) or 5 percent of the restricted range for measures not having a 0 to 100 scale (restricted range cap). New measures that have been in the Part C and D Star Rating program for 3 years or less use the hierarchal clustering methodology with mean resampling with no guardrail for the first 3 years in the program.

* * * * *

■ 27. Section 423.329 is amended by revising paragraph (b)(4) to read as follows:

§ 423.329 Determination of payments.

* * * * *

(b) * * *

(4) *Publication.* CMS publishes the risk adjustment factors established under paragraph (b)(1) of this section for the upcoming calendar year in the Advance Notice and Rate Announcement publications specified under § 422.312 of this chapter.

* * * * *

■ 28. Section 423.2440 is revised to read as follows:

§ 423.2440 Credibility adjustment.

(a) A Part D sponsor may add the credibility adjustment specified under paragraph (e) of this section to a contract's MLR if the contract's experience is partially credible, as defined in paragraph (d)(1) of this section.

(b) A Part D sponsor may not add a credibility adjustment to a contract's MLR if the contract's experience is fully credible, as defined in paragraph (d)(2) of this section.

(c) For those contract years for which a contract has non-credible experience, as defined in paragraph (d)(3) of this section, sanctions under § 423.2410(b) through (d) will not apply.

(d)(1) A contract's experience is partially credible if it is based on the experience of at least 4,800 member months and fewer than or equal to 360,000 member months.

(2) A contract's experience is fully credible if it is based on the experience of more than 360,000 member months.

(3) A contract's experience is non-credible if it is based on the experience of fewer than 4,800 member months.

(e) The credibility adjustment for partially credible experience is determined based on the number of member months for all enrollees under the contract and the factors shown in Table 1 of this section. When the number of member months used to determine credibility exactly matches a member month category listed in Table 1 of this section, the value associated with that number of member months is the credibility adjustment. The credibility adjustment for a number of member months between the values shown in Table 1 of this section is determined by linear interpolation.

TABLE 1 TO § 423.2440—CREDIBILITY ADJUSTMENTS FOR PART D CONTRACTS

Member months	Credibility adjustment (additional percentage points)
<4,800	N/A (Non-credible).
4,800	8.4%.
12,000	5.3%.
24,000	3.7%.
48,000	2.6%.
120,000	1.7%.
240,000	1.2%.
360,000	1.0%.
>360,000	0.0% (Fully credible).

Dated: May 7, 2020.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: May 20, 2020.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2020–11342 Filed 5–22–20; 8:45 am]

BILLING CODE 4120–01–P

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contacts

Emily Fonda, M.D., Deputy Chief Medical Officer, (714) 246-8887
Kris Gericke, Pharm.D., Director, Clinical Pharmacy Management, (714) 246-8460

Recommended Action(s)

Authorize the Chief Executive Officer (CEO) to retire the following existing policies and procedures in connection with the Medi-Cal Rx pharmacy benefit carve out and consistent with regulatory requirements, as follows:

1. GG.1413 Polypharmacy Management [Medi-Cal]
2. GG.1416 Pharmacy Home Program [Medi-Cal]
3. GG.1425 Prescriber Restriction [Medi-Cal]

Background/ Discussion

CalOptima regularly reviews its Policies and Procedures to ensure they are up-to-date and aligned with Federal and State health care program requirements, contractual obligations and laws as well as CalOptima operations. Effective January 1, 2021, the Department of Health Care Service (DHCS) is "carving out" the pharmacy benefit for Medi-Cal beneficiaries from managed-care plans and moving it to a fee-for-service program administered at the state level. "Medi-Cal Rx" is the name DHCS has given to this new system of how Medi-Cal pharmacy benefits will be administered through the fee-for-service delivery system. Therefore, effective January 1, 2021, MedImpact services will no longer administer pharmacy benefits for CalOptima's Medi-Cal program.

Below is information regarding the policies to be retired:

GG.1413 Polypharmacy Management [Medi-Cal]: This policy describes CalOptima's process for the monthly prescription limit through the pharmacy benefit. With the change to Medi-Cal Rx, this policy becomes obsolete.

GG.1416 Pharmacy Home Program [Medi-Cal]: This policy defines CalOptima's pharmacy lock-in program through the pharmacy benefit. With the change to Medi-Cal Rx, this policy becomes obsolete.

GG.1425 Prescriber Restriction [Medi-Cal]: This policy defines CalOptima's prescriber lock-in program through the pharmacy benefit. With the change to Medi-Cal Rx, this policy becomes obsolete.

Fiscal Impact

The recommended action to revise existing CalOptima medical policies and procedures is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

Back to Agenda

Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, and rules, CalOptima staff recommends that the Board approve retiring the presented CalOptima policies and procedures.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. GG.1413: Polypharmacy Management [Medi-Cal]
2. GG.1416: Pharmacy Home Program [Medi-Cal]
3. GG.1425: Prescriber Restriction [Medi-Cal]

/s/ Richard Sanchez — *10/28/2020*

Authorized Signature — **Date**

Back to Agenda

Policy:	GG.1413
Title:	**Polypharmacy Management**
Department:	Medical Affairs
Section:	Pharmacy Management
CEO Approval:	
Effective Date:	03/01/2002
Revised Date:	08/01/2019
Retirement Date:	01/01/2021

I. PURPOSE

This policy outlines CalOptima's commitment to improving the quality of care for **Members*** by minimizing the provision of unnecessary services and by decreasing **Polypharmacy**.

II. POLICY

A. Subject to the exclusions and exemptions described in Sections II.C. and II.D. of this Policy, prescribed medications to **Members** shall be limited to no more than six (6) prescription fills per month, unless **Prior Authorization** is obtained through the **Prior Authorization (PA)** process.

B. The prescription limit shall apply to the number of prescriptions filled in a calendar month per **Member**, regardless of where the prescription is filled, including duplicate medications, or refills.

C. The prescription limit shall not apply to the following **Members**:

1. A **Member** residing in a nursing facility, or a sub-acute care facility;

2. A **Member** receiving:

   a. Treatment for Human Immunodeficiency Virus (HIV), or Acquired Immune Deficiency Syndrome (AIDS);

   b. Immunosuppressants for transplants; or

   c. Chemotherapy medications for cancer treatment.

3. A **Member** with a chronic illness, as determined by CalOptima in accordance with Section III.D. of this Policy.

D. The prescription limit shall not apply to the following categories of prescribed medication:

1. Prescribed medication that must be submitted on paper, claims with required attachments, and compounded prescription claims;

2. Prescribed medication for a newborn that uses the mother's identification number;

3. Prescriptions submitted and subsequently reversed;

4. Family planning drugs (i.e., oral contraceptives);

5. Certain prescribed medication, or medication classes, as determined by CalOptima on a case-by-case basis.

For 20201105 BOD Review Retire 20210101]

III. PROCEDURE

A. If a pharmacy attempts to process a prescription for a prescribed medication that exceeds the prescription limit, it shall receive a message at the Point of Service (POS) to notify the pharmacy that the prescription limit has been exceeded.

B. CalOptima shall require authorization through the **PA** process for:

1. Prescribed medication fills that exceed six (6) in a calendar month for a **Member**; and

2. A prescribed medication that is exempt from the prescription limit pursuant to Section II.D. of this Policy and otherwise subject to all other CalOptima requirements, including but not limited to, a prescribed medication that:

a. Is outside **Step Therapy** limitations;

b. Is outside **Contingent Therapy** limitations;

c. Exceeds dispensing quantity limits; or

d. Exceeds frequency of billing limits.

C. The **Pharmacy Benefit Manager (PBM)** shall apply routine evaluation procedures for any **PA** requests submitted for a prescription exceeding the prescription limit.

D. In accordance with Section II.C. of this Policy, CalOptima may exempt a **Member** from the prescription limit in accordance with the following procedures:

1. A **Prescribing Provider** may request that a **Member** with a chronic illness receiving more than six (6) chronically **Medically Necessary** prescribed medications be exempted from the prescription limit by providing diagnosis information, in writing, to CalOptima.

2. Upon receipt of an exemption request, CalOptima may allow the **Member** to be exempt from the prescription limit pending the evaluation of the request by a Doctor of Pharmacy.

3. If CalOptima approves the request for exemption, it may review the **Member's** profile at a later time to reconsider the exemption.

4. If CalOptima denies the request for exemption, CalOptima may contact the **Prescribing Provider** with recommendations to change the medication regimen.

IV. ATTACHMENT(S)

A. Prior Authorization (PA) Form

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Medi-Cal Provider Pharmacy Manual
C. Title 22, California Code of Regulations (C.C.R), §51455
D. Welfare and Institutions Code, §14133.22

For 20201105 BOD Review [Retire 20210101]

VI. REGULATORY AGENCY APPROVALS

Date	Regulatory Agency
06/13/2016	Department of Health Care Services (DHCS)

VII. BOARD ACTIONS

Date	Meeting
05/02/2006	Regular Meeting of the CalOptima Board of Directors
	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2002	GG.1413	Polypharmacy Management	Medi-Cal
Revised	08/01/2002	GG.1413	Polypharmacy Management	Medi-Cal
Revised	01/01/2003	GG.1413	Polypharmacy Management	Medi-Cal
Revised	10/01/2003	GG.1413	Polypharmacy Management	Medi-Cal
Revised	07/01/2006	GG.1413	Polypharmacy Management	Medi-Cal
Revised	02/01/2008	GG.1413	Polypharmacy Management	Medi-Cal
Revised	03/01/2016	GG.1413	Polypharmacy Management	Medi-Cal
Revised	02/01/2017	GG.1413	Polypharmacy Management	Medi-Cal
Revised	10/01/2018	GG.1413	Polypharmacy Management	Medi-Cal
Revised	08/01/2019	GG.1413	Polypharmacy Management	Medi-Cal
Retirement	01/01/2021	GG.1413	Polypharmacy Management	Medi-Cal

For 20201105 BOD Review [Retire 20210101]

IX. GLOSSARY

Term	Definition
Contingent Therapy	A utilization management process which restricts a drug to a specific age, gender, or related drug therapy. If it is Medically Necessary for a Member to use the medication and the contingent therapy restriction is not met, the prescriber can request coverage by submitting a prior authorization request.
Medically Necessary	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
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.
Pharmacy Benefits Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Polypharmacy	The simultaneous use of multiple medications by a single Member, for one or more conditions.
Prescribing Provider	The physician, osteopath, podiatrist, dentist, optometrist or authorized mid-level medical Practitioner who prescribes a medication for a Member.
Prior Authorization (PA)	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Step Therapy	A utilization management process which requires a trial of a first-line formulary medication prior to receiving the second-line medication. If it is Medically Necessary for a Member to use the medication as initial therapy, the prescriber can request coverage by submitting a prior authorization request.

For 20201105 BOD Review [Retire 20210101]

CalOptima
A Public Agency
Better. Together.

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Submit requests to the Prior Authorization Center at:

	Fax	Appeal Fax	Call
Medi-Cal/ CalWrap	858-357-2557	714-954-2280	888-807-5705
OneCare HMO SNP (Medicare Part D)	858-357-2556	858-357-2556	800-819-5532
OneCare Connect (Medicare-Medicaid)	858-357-2556	858-357-2556	800-819-5480

What is the urgency?	Request is for a hospital discharge medication?
☐ Standard ☐ Urgent* ☐ Retroactive	☐ Yes ☐ No

* The prescriber attests that applying the standard turn-around time could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

PATIENT INFORMATION

Patient Name: _____

Patient CalOptima ID #: _____

Gender: ☐ Male ☐ Female DOB: _____

Other Primary Insurance? ☐ Yes ☐ No ☐ Unknown

Name of Primary Insurance: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Specialty: _____

Prescriber NPI #: _____

Prescriber Signature: _____

For Medicare Part D, an enrollee, an enrollee's representative, or an enrollee's prescribing physician or other prescriber may request a coverage determination

PATIENT LOCATION INFORMATION

Patient Location:
☐ Home ☐ B&C ☐ Sub-Acute ☐ SNF ☐ ICF

Name of Facility: _____

Facility Phone #: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy NPI #: _____

Pharmacy Phone #: _____

Pharmacy Fax #: _____

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY
Drug Name: _____ NDC#: _____			

REVIEW CRITERIA:

What is the diagnosis? _____ **OR** ICD-10 code: _____

New Therapy? ☐ Yes ☐ No # Refills? _____ Date of Rx: _____

Medical Justification Supporting Statement *(include formulary drugs that have been tried, why the requested drug is medically required, why formulary drugs would not be appropriate, and applicable labs).*

If applicable, include dates and reason for retroactive authorization requests.

The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

For 20201105 BOD Review |Retire 20210101

Confidential information
Fax is intended only for the individual to whom it is addressed.
If you are not the intended, do not read, copy, or distr bute this information. Thank You.

Back to Agenda Back to Item

Policy:	GG.1416
Title:	**Pharmacy Home Program**
Department:	Medical Affairs
Section:	Pharmacy Management
CEO Approval:	
Effective Date:	10/01/1998
Revised Date:	08/01/2019
Retirement Date:	01/01/2021

I. PURPOSE

This policy establishes the CalOptima **Member*** **Pharmacy Home** Program to enable physicians and **Pharmacists** to provide quality care by reducing drug abuse or injury from over medication or drug interactions.

II. POLICY

A. CalOptima recognizes that it is in the best interest of a **Member** to utilize a single **Pharmacy** for pharmaceutical services, particularly a **Member** with no **Primary Care Physician (PCP)** or a **Member** who receives prescriptions from multiple prescribers.

B. Subject to the exceptions set forth in this Policy, a **Member** who has filled prescriptions at four (4) or more **Pharmacies** in a two (2) month period shall utilize one (1) provider of pharmaceutical services (a "**Pharmacy Home**") for a twelve (12)-month period. If such **Member** does not identify a **Pharmacy Home** within the time frames set forth in this Policy, CalOptima shall identify a **Pharmacy Home** on the **Member's** behalf in accordance with the provisions of this Policy.

C. Subject to the exceptions set forth in this Policy, a **Selected Member** shall only obtain pharmaceutical services from their **Pharmacy Home** during the **Lock-in Period** in accordance with Section III.E of this Policy.

D. A **Selected Member** may obtain pharmaceutical services from a **Pharmacy** that is not his or her **Pharmacy Home** as follows:

1. In accordance with CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies;

2. In accordance with the provisions of Section III.F of this Policy; or

3. If a **Selected Member** needs pharmaceutical services that their **Pharmacy Home** is unable to provide.

E. CalOptima shall inform a **Selected Member** that it shall deny payment for claims for pharmaceutical services submitted by any **Pharmacy** other than the **Selected Member's Pharmacy Home**, except as otherwise provided in this Policy.

III. PROCEDURE

A. Selection of **Members**

For 20201105 BOD Review [Retire 20210101]

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

Back to Agenda Back to Item

1. CalOptima may identify a **Member** as a **Selected Member** if **Pharmacy** claims utilization reports indicate that the **Member** has filled prescriptions at four (4) or more **Pharmacies** in a two (2) month period.

B. Selection of **Pharmacy Home**

1. Upon identification of a **Selected Member** as described in Section III.A. of this Policy, CalOptima shall provide the **Selected Member** with a written notice thirty (30) calendar days prior to the **Selected Member's** scheduled participation in the **Pharmacy Home** Program. The notice shall:

   a. Inform the **Selected Member** of their participation in the **Pharmacy Home** Program; and

   b. Request that the **Selected Member** identify a **Pharmacy Home** no later than thirty (30) calendar days after the date of the notice, in accordance with the criteria for identification of a **Pharmacy Home** set forth in Section III.C.1. of this Policy.

2. Upon receipt of the **Selected Member's Pharmacy Home** Selection Form, CalOptima shall notify the **Selected Member**, in writing, of the date on which the **Lock-in Period** shall be implemented.

3. If the **Selected Member** does not identify a **Pharmacy Home** within thirty (30) calendar days after the date of CalOptima's request, CalOptima shall provide a written notice to the **Selected Member** that identifies:

   a. A **Pharmacy Home** for the **Selected Member** that CalOptima shall identify in accordance with the provisions of Section III.B.4. of this Policy;

   b. The date on which the **Lock-in Period** shall be implemented; and

   c. The name, address, and contact information for the **Pharmacy Home**.

4. CalOptima shall identify a **Pharmacy Home** for a **Selected Member** from the list described in Section III.C.2. of this Policy and in the following order:

   a. The **Participating Pharmacy** described in Section III.C.1. of this Policy at which the **Selected Member** has filled prescriptions within the two (2) month period prior to CalOptima's issuance of the request described in Section III.B.1. of this Policy, starting with the most recent in time in descending order to the least recent in time; or

   b. The **Participating Pharmacy** described in Section III.C.1 of this Policy that is accessible within ten (10) miles or twenty (20) minutes of the **Selected Member's** residence and is:

      i. Within the zip code of the **Selected Member's** residence and most proximate to the **Selected Member's** residence; or

      ii. Within the city in which the **Selected Member** resides and most proximate to the **Selected Member's** residence, if there is no **Participating Pharmacy** described in Section III.B.4(b)(i) of this Policy that is eligible to participate in the **Pharmacy Home** Program.

For 20201105 BOD Review [Retire 20210101]

C. Pharmacy Home

1. Subject to the provisions of Section III.C.3 of this Policy, a **Pharmacy** shall be eligible for designation as a **Pharmacy Home** if such **Pharmacy** is a **Participating Pharmacy**.

2. CalOptima shall maintain and periodically update a list of **Participating Pharmacies** that are eligible for designation as a **Pharmacy Home**.

3. Subsequent to the establishment of the **Pharmacy Home** Program, CalOptima may determine that a **Pharmacy** is not eligible to serve as a **Pharmacy Home** if CalOptima **Sanction**s such a **Pharmacy** in accordance with the provisions of CalOptima Policy GG.1408: Pharmacy Audits and Reviews.

   a. CalOptima shall provide ten (10) calendar days written notice to the **Pharmacy** of its intent to remove the **Pharmacy**'s designation as a **Pharmacy Home**;

   b. If a **Pharmacy** wishes to dispute CalOptima's decision to remove the **Pharmacy**'s designation as a **Pharmacy Home**, it may file a **Complaint** and request a hearing in accordance with CalOptima Policy HH.1101: CalOptima Provider **Complaint**; and

   c. If CalOptima determines that a **Pharmacy** is not eligible to serve as a **Pharmacy Home**, CalOptima shall remove the **Pharmacy** from the **Pharmacy Home** list described in Section III.C.2 of this Policy for the period that coincides with the terms of the **Sanction** or for twelve (12) months, whichever period is less. The removal shall not be effective until after the issuance of a final decision upholding the proposed action if the **Pharmacy** files a **Complaint** or requests a hearing.

4. CalOptima shall add a **Pharmacy** that is identified as eligible for designation as a **Pharmacy Home** to the **Pharmacy Home** list at its next scheduled update.

D. **Selected Members** Affected by Removal of **Pharmacy Home**

1. If a **Selected Member's Pharmacy Home** becomes ineligible to serve as a **Pharmacy Home**, CalOptima shall auto assign that **Selected Member** to another **Pharmacy Home** in accordance with the provisions of Section III.B.4 of this Policy.

2. CalOptima shall notify the **Selected Member**, in writing, no less than three (3) working days prior to the effective date of such auto assignment to another **Pharmacy Home**. The notice shall contain:

   a. Information that the **Selected Member's Pharmacy Home** is no longer eligible to serve as a **Pharmacy Home**;

   b. The name, address, and contact information for the new **Pharmacy Home**;

   c. The date of the **Pharmacy Home** transition; and

   d. Instructions on how to request a '**For Cause**' change of **Pharmacy Home** in accordance with Section III.F.2 of this Policy.

For 20201105 BOD Review [Retire 20210101]

Back to Agenda Back to Item

E. **Lock-in Period**

1. A **Selected Member's Lock-in Period** shall be the twelve (12)-month period that commences on the date of the notice described in Section III.B.1 of this Policy.

2. Except as otherwise provided in this Policy, on and after the effective date of the **Lock-in Period**, a **Selected Member** shall only obtain pharmaceutical services from their **Pharmacy Home** and CalOptima shall not issue any payment on behalf of a **Selected Member** for pharmaceutical services provided by a **Pharmacy** other than the **Selected Member's Pharmacy Home**.

3. CalOptima may issue payment for pharmaceutical services provided by a **Pharmacy** other than a **Pharmacy Home** for a **Selected Member** for emergency medications in accordance with CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies, or for pharmaceutical services that the **Pharmacy Home** is unable to provide to a **Selected Member**.

F. **For Cause** Requests. A **Selected Member** may request a change to his or her status as follows:

1. A **Selected Member** may be exempt from the **Pharmacy Home** Program if the **Selected Member**:

   a. Has a foster care **Aid Code** or is identified by the County of Orange Social Services Agency as being in the foster care system; or

   b. Identifies access or quality of care issues that affects the **Selected Member's** ability to obtain needed **Covered Services** or that subject the **Selected Member** to unnecessary medical risk.

2. A **Selected Member** may request a change to his or her **Pharmacy Home** based upon:

   a. A change in the **Selected Member's** residence;

   b. Identification of access or quality of care issues that affect the **Selected Member's** ability to obtain needed **Covered Services** or that subject the **Selected Member** to unnecessary medical risk; or

   c. Auto assignment to another **Pharmacy Home** when CalOptima determines that a **Selected Member's Pharmacy Home** is ineligible to serve as a **Pharmacy Home** as described in Section III.D of this Policy.

G. Processes relating to **For Cause** Requests. A **Selected Member** may request a change to their status in accordance with the following guidelines:

1. A **Selected Member** who wishes to request a change of **Pharmacy Home** may file a request by telephone, in writing, or in person to CalOptima's Customer Service Department;

2. The **Selected Member** shall explain the reasons for which they wish to change their **Pharmacy Home** or be exempt from the **Pharmacy Home** Program;

For 20201105 BOD Review [Retire 20210101]

Back to Agenda Back to Item

3. The Customer Service Department shall refer a request for change of a **Selected Member's** status to the Pharmacy Management Department on the date on which the Customer Service Department receives such request;

4. The Pharmacy Management Department shall make a final determination regarding a request from a **Selected Member** to change their status within five (5) working days after the Pharmacy Management Department's receipt of such request from the Customer Service Department; and

5. If a **Selected Member's** request to change his or her status is approved, such change shall become effective within thirty (30) calendar days after the date of the request, unless circumstances warrant an immediate change.

H. **Member** Rights

1. A **Selected Member** shall have the right to file a **Complaint** and request a State Fair Hearing if the **Selected Member** disputes participation in the **Pharmacy Home** Program in accordance with CalOptima Policies HH.1102: CalOptima Member Complaint and HH.1108: State Hearing Process and Procedures.

2. If a **Selected Member** requests a State Fair Hearing with regard to the proposed **Pharmacy Home**, the **Selected Member's Lock-in Period** shall not commence until after the issuance of a final decision upholding the proposed action.

I. Provider Rights. A **Pharmacy** that is deemed ineligible to serve as a **Pharmacy Home** shall have the right to file a **Complaint** and to request a hearing in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. CalOptima Participating Pharmacy Agreement
D. CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies.
E. CalOptima Policy GG.1408: Pharmacy Audits and Reviews
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. CalOptima Policy HH.1102: CalOptima Member Complaint
H. CalOptima Policy HH.1108: State Hearing Process and Procedures

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/09/2016	Department of Health Care Services (DHCS)

For 20201105 BOD Review [Retire 20210101]

Back to Agenda Back to Item

VII. BOARD ACTION(S)

Date	Meeting
01/10/2006	Regular Meeting of the CalOptima Board of Directors
	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2004	GG.1416	Pharmacy Home Program	Medi-Cal
Revised	06/01/2004	GG.1416	Pharmacy Home Program	Medi-Cal
Revised	04/01/2006	GG.1416	Pharmacy Home Program	Medi-Cal
Revised	07/01/2016	GG.1416	Pharmacy Home Program	Medi-Cal
Revised	04/01/2017	GG.1416	Pharmacy Home Program	Medi-Cal
Revised	10/01/2018	GG.1416	Pharmacy Home Program	Medi-Cal
Revised	08/01/2019	GG.1416	Pharmacy Home Program	Medi-Cal
Retirement	01/01/2021	GG.1416	Pharmacy Home Program	Medi-Cal

For 20201105 BOD Review [Retire 20210101]

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.
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.
Covered Services	Those services set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, which are included as Covered Services under CalOptima's contract with the Department of Health Services (DHS) and medically necessary as described in Attachment A of the CalOptima Contract for Health Care Services.
For Cause	Reasons for which a Selected Member may change a Pharmacy Home or be exempt from the requirements of this policy.
Lock-in Period	The twelve (12) month period of time during which a Selected Member shall remain with a Pharmacy Home.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, Department of Health Services, or the United States Social Security Administration, who is not eligible for Medicare.
Participating Pharmacy	A Pharmacy that is credentialed by, and contracted with, CalOptima to provide pharmaceutical services to Members.
Pharmacist	A person to whom the State Board of Pharmacy has issued a license, authorizing the person to practice pharmacy
Pharmacy	An area, place, or premises licensed by the State Board of Pharmacy in which the profession of pharmacy is practiced and where prescriptions are compounded and dispensed, and for the purpose of this policy, the licensed dispensing area of a community clinic.
Pharmacy Home	The Pharmacy of record at which a Selected Member shall fill all prescriptions during a Lock-in Period.
Primary Care Physician (PCP)	A physician who focuses his or her practice of medicine to general practice or who is a board certified or board eligible internist, pediatrician, obstetrician/ gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care under the CalOptima program.
Sanction	Action taken by CalOptima including, without limitations, restrictions, monetary fines, termination or a combination thereof, based on a Health Network's or its delegate's, subcontractor's, or any Health Network partner's failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to the CalOptima Medi-Cal program.
Selected Member	A Member whom CalOptima identifies for participation in the Pharmacy Home Program in accordance with the terms and conditions of this policy.

For 20201105 BOD Review [Retire 20210101]

Policy:	GG.1425
Title:	**Prescriber Restriction Program**
Department:	Medical Management
Section:	Pharmacy Management
Interim CEO Approval:	
Effective Date:	08/01/2016
Revised Date:	02/06/2020
Retirement Date:	01/01/2021
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20201105 POD Review [Retire 20210101]

I. PURPOSE

This policy describes the criteria and process by which a Member is assigned to a Designated Prescriber to receive controlled substance medications through the Prescriber Restriction Program.

II. POLICY

A. The Chief Medical Officer (CMO) or Designee may place a CalOptima Member to a Designated Prescriber to obtain controlled substance medications, in an outpatient setting, if:

a. The Member obtains controlled substance prescriptions from four (4) or more Prescribers in a two (2) month period; or

b. Upon referral by providers, Health Network staff, or CalOptima staff demonstrating that the Selected Member have obtained controlled substances from multiple prescribers as per the Controlled Substances Utilization Review and Evaluation System (CURES) report.

B. Subject to the exceptions set forth in this policy, a Selected Member shall only obtain prescription medication services from his or her Designated Prescriber during the Lock-in Period.

C. The Designated Prescriber shall be the Selected Member's Primary Care Physician (PCP).

D. Pharmaceutical services may be provided to a Selected Member pursuant to a prescription from a Prescriber other than the Designated Prescriber for emergency situations in accordance with CalOptima Policies GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies; and GG.1639: Post-Hospital Discharge Medication Supply.

E. A Prescriber restriction shall be effective for a period of twelve (12) calendar months.

1. Thirty (30) calendar days prior to the end of the Selected Member's restricted period, CalOptima's Pharmacy Management Department staff shall review authorizations, claims, and other documentation related to the restriction and discuss the case with the Member's appropriate Provider(s).

Back to Agenda Back to Item

2. The CMO or Designee may continue the restriction for a Member for an additional period of twelve (12) calendar months if:

   a. The Selected Member continues to obtain controlled substance medications from prescribers other than the Designated Prescriber(s); or

   b. Upon continued recommendation by Providers, Health Network staff, or CalOptima staff using the Controlled Substances Utilization Review and Evaluation System (CURES) report.

F. Requests to place a Member on a restricted status may be made to the CalOptima Pharmacy Management Department by Providers, Health Network staff, or CalOptima staff.

G. The restriction on a Member for controlled substance medications shall not affect the eligibility of the Member to receive other Medi-Cal benefits, or apply in any instance where an emergency exists which requires immediate treatment.

H. The following information will be utilized when evaluating a request for restricted status:

1. Review of pharmacy claims data for the Member in question and review of claims/encounter data on the Member's usage of specific services.

2. Communication with Prescribers about the Member's use of drugs and the current and/or historical usage of medications, and possible efforts by the physician(s) to monitor/manage the drug usage.

I. CalOptima shall inform a Selected Member that it shall deny payment for controlled substance prescriptions for pharmaceutical services by any Prescriber other than the Designated Prescriber, except as otherwise provided in this Policy.

J. Members excluded from the Prescriber Prescription Program, shall include:

1. Members being treated for advanced cancer; and

2. Members receiving hospice, palliative, or end-of-life care.

III. PROCEDURE

A. Identification of Selected Members

1. CalOptima may identify a Member as a Selected Member for the Provider Restriction Program if:

   a. Pharmacy claims utilization reports indicate the Member has filled controlled substance prescriptions from four (4) or more Prescribers in a two (2) month period; or

   b. Upon referral by providers, Health Network staff, or CalOptima staff demonstrating that the Member has obtained controlled substances from multiple prescribers as per the Controlled Substances Utilization Review and Evaluation System (CURES) report.

B. Member Notification

For 20201105 BOD Review [Retire 20210101]

1. Upon identification of a Selected Member, CalOptima shall provide the Selected Member with a written notice thirty (30) calendar days prior to the Selected Member's scheduled participation in the Prescriber Restriction Program. The notice shall:

   a. Inform the Selected Member of their participation in the Prescriber Restriction Program;

   b. The Member's Designated Prescriber and Prescriber restriction dates; and

   c. The right to file a complaint and request a State Hearing if the Selected Member disputes participation in the Prescriber Restriction Program.

C. For Cause Requests

1. A Selected Member may request a change to their restricted status by contacting the CalOptima Customer Service Department if the Selected Member identifies that participation in the Prescriber Restriction program would present an access or quality of care issue(s) that affects his/her ability to obtain needed Covered Services or that subject the Selected Member to unnecessary medical risk.

2. A Selected Member may request to change his or her assigned Designated Prescriber based upon:

   a. A change in the Selected Member's PCP; or

   b. Identification of access or quality of care issues that affect the Selected Member's ability to obtain needed controlled substance prescriptions or that subject the Selected Member to unnecessary medical risk.

D. Member Rights

1. A Selected Member shall have the right to file a Grievance or Appeal and request a State Hearing if the Selected Member disputes participation in the Prescriber Restriction Program in accordance with CalOptima Policies HH.1102: Member Grievance, GG.1510: Appeal Process, and HH.1108: State Hearing Process and Procedures.

2. If a Selected Member requests a State Hearing with regard to the proposed Prescriber Restriction, the Selected Member's Lock-in Period shall not commence until after the issuance of a final decision upholding the proposed action.

IV. ATTACHMENT(S)

A. Medication Case Review Form
B. Member Notice
C. Prescriber Notice

V. REFERENCE(S)

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies
C. CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply
D. CalOptima Policy GG.1510: Appeal Process
E. CalOptima Policy HH.1102: Member Grievance

For 20201105 BOD Review [Retire 20210101]

F. CalOptima Policy HH.1108: State Hearing Process and Procedures
G. Title 42, Code of Federal Regulations (C.F.R), §440.230(d)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
09/21/2020	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Board Approval
02/06/2020	Regular Meeting of the CalOptima Board of Directors
	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2016	GG.1425	Prescriber Restriction Program	Medi-Cal
Revised	04/01/2017	GG.1425	Prescriber Restriction Program	Medi-Cal
Revised	10/01/2018	GG.1425	Prescriber Restriction Program	Medi-Cal
Revised	02/06/2020	GG.1425	Prescriber Restriction Program	Medi-Cal
Retirement	01/01/2021	GG.1425	Prescriber Restriction Program	Medi-Cal

For 20201105 BOD Review [Retire 20210101]

IX. GLOSSARY

Term	Definition
Appeal	A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service.
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.
Designated Prescriber	For the purposes of this policy as the Prescriber of record at which a Selected Member shall fill all prescriptions during the Lock-in Period. The Designated Prescriber shall be the member's primary care physician.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
For Cause	For the purposes of this policy, as reasons for which a Selected Member may change a Designated Prescriber or be exempt from the requirements of this policy.
Grievance	An expression of dissatisfaction about any matter other than an Adverse Benefit Determination.
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.
Lock-in Period	For the purposes of this policy as the twelve (12)-month period of time during which a Selected Member shall remain restricted to a Designated Prescriber.
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 program.
Primary Care Provider (PCP)	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Selected Member	For the purposes of this policy, as a Member whom CalOptima identifies for assignment to a Designated Prescriber in accordance with the terms and conditions of this policy.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program.

For 20201105 BOD Review [Retire 20210101]

Medi-Cal CalOptima A Public Agency Better. Together.

MEDICATION CASE REVIEW

Reviewer: **Date:**
Initial Review Date: **Revaluation Date:**

Member Name:	DOB:
CIN:	Health Network:
Reason for Review:	
Medical Problems/Comments:	
ER Activity / Phone Log Activity:	
PCP: Other Prescriber:	PCP Phone: Other Phone:
Medications:	
PCP / Prescriber Comments:	
Recommendation of PCP / Prescriber:	
CalOptima Comments:	
Chief Medical Officer/Medical Director Review	
☐ Prior Authorization required for all Controlled Medications ☐ Prior Authorization required for Specific Medications Medications:	
Chief Medical Officer/Medical Director Signature	
Effective Dates of Restricted Status:	

For 20201105 BOD Review [Retire 20210101]

Back to Agenda Back to Item

[date]

Dear CalOptima Member:

Did you know that certain prescriptions can become addictive or are dangerous if they are overused? These drugs are called "controlled medications." Some examples of these drugs are narcotics, sedatives and amphetamines.

As the Chief Medical Officer at CalOptima, I work with our primary care doctors to make sure our members receive prescriptions that are appropriate for treating their health problems.

CalOptima recently reviewed your prescription records. As a result, your primary care doctor and I are concerned about your use of controlled medications (or other specific drug). Because of this concern, CalOptima has placed the prescriber part of your Medi-Cal medication coverage on "Restricted Status."

Restricted Status means that if you get a prescription from someone other than your designated prescriber, CalOptima must review and approve your prescriptions — before they are filled — through the prior authorization (PA) process for all controlled medications (or other specific drug). Your designated prescriber is (Dr. FIRST NAME LAST NAME).

Before this restriction ends, your case will be reviewed by CalOptima to determine if the Restricted Status should continue or be removed. Please contact CalOptima Customer Service if you have questions about your Restricted Status or about the prescription approval process.

Sincerely,

Chief Medical Officer
CalOptima

For 20201105 BOD Review [Retire 20210101]

If you disagree with your placement on Restricted Status, you may call CalOptima Customer Service at **1-714-246-8500** or toll-free at **1-888-587-8088** to file a grievance. You also have the right to request a State Fair Hearing if you would like to appeal a decision made by CalOptima. To request a State Fair Hearing, call the State Department of Social Services at 1-800-952-5253.

For 20201105 BOD Review [Retire 20210101]

[date]

RE: Member Name
Birth date:
CIN #:

Effective Dates of Restricted Status:
From:
To:

Dear Provider:
CalOptima recently reviewed this member's prescription and pharmacy records. As a result, we are concerned about the use of controlled medications (or other specific drug). Because of the concern of overuse of controlled medications, CalOptima has restricted controlled substance prescriptions to

- ☐ Prior Authorization required for all Controlled Medications
- ☐ Prior Authorization required for Specific Medications:

Please contact the CalOptima Pharmacy Management Department at 714-246-8471 if you have any other questions concerning this member.

Sincerely,

Chief Medical Officer, CalOptima

For 20201105 BOD Review [Retire 20210101]

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

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

Contact
Michelle Laughlin, Executive Director Network Operations (657) 900-1116

Recommended Actions
Approve modifications to the following Policies pursuant to CalOptima's annual review process:
1. Policy EE.1127: Disposable Incontinence Supplies Network
2. Policy EE.1135: Long Term Care Facility Contracting

Background/Discussion
Updates to the Policies described below have been provided pursuant to a routine review process to confirm they are current, and in alignment with federal and state program, regulatory, and contractual requirements.

Policy EE.1127: Disposable Incontinence Supplies Network
This policy provides the guidelines and process under which Disposable Incontinence Supply vendors are eligible to be contracted with and reimbursed by CalOptima. Vendors who have met qualifying criteria via CalOptima's Request for Proposal process and have entered and remain active via an ancillary services contract are eligible to provide Disposable Incontinence Supply services to CalOptima members. CalOptima provides reimbursement at a contracted rate contingent on the service being covered under the member's plan and a CalOptima financial responsibility. Non-contracted vendors will be eligible for reimbursement only in cases where CalOptima's Utilization Management department authorizes that vendor to provide a particular disposable incontinence supply item not available through any of CalOptima's contracted vendors.

Pursuant to the Policy review process, staff proposes the following changes to the policy:
- Addition of "OneCare" to the "Applicable to" section as this line of business qualifies for incontinence supplies as a covered benefit through OneCare's Medi-Cal wrap-around benefit.
- Language added for clarification that disposable incontinence supplies are provided to the Member when they are a covered benefit under the Member's plan and CalOptima is financially responsible for these services.

Policy EE.1135: Long Term Care Facility Contracting
This policy provides the guidelines and process for CalOptima to enter into contracts and Letters of Agreement (LOA) with Long Term Care Facilities. In order for CalOptima to contract with a Long Term Care (LTC) Facilities, the facility is required to be licensed and certified by the California Department of Public Health (CDPH) and approved by the Department of Health Care Services (DHCS) for participation in the Medi-Cal program. In addition, CalOptima staff assesses whether the facility meets the needs of the Member, and in cases where it does not, place the Member in an out of network facility. LOAs are utilized in situations when the Member's needs justify the use of a non-contracted facility,

Back to Agenda

provided that the facility meets the CDPH and DHCS criteria as stated above (and that the placement is justified based on Member need). In cases where a Member is admitted to a LTC facility under the Medicare benefit, Medicare will reimburse the facility for the member's co-insurance for days 1 – 19 of the stay, and CalOptima will reimburse the facility for the member's Medicare co-insurance for day 20 through day 100 of the Member's stay, regardless of the LTC facility's contract status.

Pursuant to the review process, staff proposes the following changes to this policy:

- Addition of "OneCare" to the "Applicable to" section as this line of business qualifies for LTC services as a covered benefit through OneCare's Medi-Cal wrap-around benefit.
- Addition of "PACE" to the "Applicable to" section as this line of business qualifies for LTC services as a covered benefit through PACE.

Fiscal Impact

The recommended action to approve revisions to CalOptima Policies EE.1127 and EE.1135 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget.

Rationale for Recommendation

These policy updates will serve as a guideline for providers of disposable incontinence supplies and LTC services and align with current operational procedures.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Policy EE.1127: Disposable Incontinence Supplies Network (Redline and Clean versions)
2. Policy EE.1135: Long Term Care Facility Contracting (Redline and Clean versions)

/s/ Richard Sanchez *10/28/2020*
Authorized Signature **Date**

Back to Agenda

Policy:	EE.1127Δ
Title:	**Disposable Incontinence Supplies Network**
Department:	Contracting
Section:	Not Applicable
CEO Approval:	~~*Michael Schrader*~~
Effective Date:	01/01/2010
Revised Date:	~~06/01/2019~~
Applicable to:	☒ Medi-Cal ☒ ~~-OneCare (Medi-Cal wrap-around)~~ ☒ OneCare Connect ☒ PACE ☐ Administrative

For 20201105 BOD Review Only

I. PURPOSE

This policy describes the closed network of contracted vendors used for the provision of disposable incontinence supplies to Members.

II. POLICY

A. Subject to the provisions of this policy, only a contracted vendor shall be eligible for reimbursement of disposable incontinence supplies provided to a Member. The contracted vendors for disposable incontinence supplies are limited to vendors that:

1. Met all qualifying requirements as specified in CalOptima's Request for Proposals (RFP) for Incontinence Supplies dated July 16, 2018;

2. Entered into an Ancillary Services Contract with CalOptima for disposable incontinence supplies as of January 1, 2019; and

3. Execute renewal amendments to remain contracted with CalOptima.

B. CalOptima shall reimburse a contracted vendor for disposable incontinence supplies provided to a CalOptima Member in accordance with the provisions of this policy, and at contracted rates when the disposable incontinence supplies are a covered benefit under the Member's plan and CalOptima is financially responsible for these services.

C. Upon a Health Network's request, a CalOptima contracted vendor for disposable incontinence supplies shall agree to contract with a Health Network, and shall extend to the Health Network the same reimbursement rates for disposable incontinence supplies as negotiated with CalOptima.

D. CalOptima shall provide Members, Health Networks, and Providers with access to the names of contracted vendors in the Provider Directory, through the CalOptima website's Ancillary and Facility Search Tool, and upon request for such information.

III. PROCEDURE

A. CalOptima's Contracting Department shall oversee and manage CalOptima's contracting process for disposable incontinence supplies in accordance with the Ancillary Services Contract and with the terms and conditions of this Policy.

1. A non-contracted vendor shall not be eligible to receive reimbursement from CalOptima for disposable incontinence supplies provided to a Member unless CalOptima's Utilization Management Department authorizes the non-contracted vendor to provide a disposable incontinence supply item that is not available through any of CalOptima's network of contracted vendors.

B. For contract renewal purposes, CalOptima shall evaluate the contracted vendor's performance prior to contract expiration through review of:

1. Member Grievances against a contracted vendor;

2. Data collected from regularly submitted contracted vendor reports to Utilization Management including, but not limited to:

a. Utilization reports, and

b. Customer satisfaction reports; and

3. Feedback from other CalOptima departments and the Health Networks to identify any significant unresolved issues with the contracted vendors.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Ancillary Services Contract
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima PACE Program Agreement
~~C.~~E. CalOptima Contract for Health Care Services
~~D.A. CalOptima PACE Program Agreement~~
~~E.~~F. CalOptima Request for Proposals (RFP) for Incontinence Supplies
~~F.A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
G. Medi-Cal ~~Managed Care~~Provider Manual; Incontinence Medical Supplies: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/incontex_a04p00.doc

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
02/02/2010	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
03/05/2009	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors

For 2020/105 BOD Review Only

For 20201105 BOD Review Only

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2004	EE.1127	Medical Supply and Incontinence Supply Network	Medi-Cal
Revised	08/01/2008	EE.1127	Medical and Incontinence Supplies Network	Medi-Cal
Revised	01/01/2010	EE.1127	Disposable Incontinence Supplies Network	Medi-Cal
Revised	08/01/2016	EE.1127	Disposable Incontinence Supplies Network	Medi-Cal OneCare Connect PACE
Revised	08/01/2018	EE.1127	Disposable Incontinence Supplies Network	Medi-Cal OneCare Connect PACE
Revised	06/01/2019	EE.1127	Disposable Incontinence Supplies Network	Medi-Cal OneCare Connect PACE
Revised		EE.1127Δ	Disposable Incontinence Supplies Network	Medi-Cal OneCare OneCare Connect PACE

For 20201105 BOD Review Only

IX. GLOSSARY

Term	Definition
~~CalOptima~~	~~For the purposes of the policy, CalOptima includes CalOptima Direct (COD) and CalOptima Community Network (CCN).~~
Grievance	Medi-Cal: A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by the MCP to make an authorization decision. Also a Complaint from a Member related to Medi-Cal benefits and services pursuant to Welfare and Institutions Code Section 14450 and California Health and Safety Code Section 1368 and 1368.1.~~An expression of dissatisfaction about any matter other than an adverse benefit determination.~~ OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. OneCare Connect: Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint."~~Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action.~~ PACE: A complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of Participant care. A Grievance may include, but is not limited to: 1. The quality of services a Participant receives in the home, at the PACE Center or in an inpatient stay (hospital, rehabilitative facility, skilled nursing facility, intermediate care facility or residential care facility); 2. Waiting times on the telephone, in the waiting room or exam room; 3. Behavior of any of the care providers or PACE staff members; 4. Adequacy of center facilities; 5. Quality of the food provided; 6. Transportation services; and 7. A violation of a Participant's rights.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

For 2020 105 BOD Review Only

Term	Definition
Member	A~~n enrollee~~ ~~Member~~ beneficiary ~~of~~ enrolled in a CalOptima program.
Provider	~~All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who are licensed to furnish Covered Services.~~Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.~~A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.~~

For 20201105 BOD Review Only

Policy:	EE.1127Δ
Title:	**Disposable Incontinence Supplies Network**
Department:	Contracting
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/01/2010
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

For 20201105 BOD Review Only

I. PURPOSE

This policy describes the closed network of contracted vendors used for the provision of disposable incontinence supplies to Members.

II. POLICY

A. Subject to the provisions of this policy, only a contracted vendor shall be eligible for reimbursement of disposable incontinence supplies provided to a Member. The contracted vendors for disposable incontinence supplies are limited to vendors that:

1. Met all qualifying requirements as specified in CalOptima's Request for Proposals (RFP) for Incontinence Supplies dated July 16, 2018;

2. Entered into an Ancillary Services Contract with CalOptima for disposable incontinence supplies as of January 1, 2019; and

3. Execute renewal amendments to remain contracted with CalOptima.

B. CalOptima shall reimburse a contracted vendor for disposable incontinence supplies provided to a CalOptima Member in accordance with the provisions of this policy, and at contracted rates when the disposable incontinence supplies are a covered benefit under the Member's plan and CalOptima is financially responsible for these services.

C. Upon a Health Network's request, a CalOptima contracted vendor for disposable incontinence supplies shall agree to contract with a Health Network, and shall extend to the Health Network the same reimbursement rates for disposable incontinence supplies as negotiated with CalOptima.

D. CalOptima shall provide Members, Health Networks, and Providers with access to the names of contracted vendors in the Provider Directory, through the CalOptima website's Ancillary and Facility Search Tool, and upon request for such information.

III. PROCEDURE

A. CalOptima's Contracting Department shall oversee and manage CalOptima's contracting process for disposable incontinence supplies in accordance with the Ancillary Services Contract and with the terms and conditions of this Policy.

1. A non-contracted vendor shall not be eligible to receive reimbursement from CalOptima for disposable incontinence supplies provided to a Member unless CalOptima's Utilization Management Department authorizes the non-contracted vendor to provide a disposable incontinence supply item that is not available through any of CalOptima's network of contracted vendors.

B. For contract renewal purposes, CalOptima shall evaluate the contracted vendor's performance prior to contract expiration through review of:

1. Member Grievances against a contracted vendor;

2. Data collected from regularly submitted contracted vendor reports to Utilization Management including, but not limited to:

a. Utilization reports, and

b. Customer satisfaction reports; and

3. Feedback from other CalOptima departments and the Health Networks to identify any significant unresolved issues with the contracted vendors.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Ancillary Services Contract
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima PACE Program Agreement
E. CalOptima Contract for Health Care Services
F. CalOptima Request for Proposals (RFP) for Incontinence Supplies
G. Medi-Cal Provider Manual; Incontinence Medical Supplies: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/incontex_a04p00.doc

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
02/02/2010	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
03/05/2009	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors

For 20201105 BOD Review Only

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2004	EE.1127	Medical Supply and Incontinence Supply Network	Medi-Cal
Revised	08/01/2008	EE.1127	Medical and Incontinence Supplies Network	Medi-Cal
Revised	01/01/2010	EE.1127	Disposable Incontinence Supplies Network	Medi-Cal
Revised	08/01/2016	EE.1127	Disposable Incontinence Supplies Network	Medi-Cal OneCare Connect PACE
Revised	08/01/2018	EE.1127	Disposable Incontinence Supplies Network	Medi-Cal OneCare Connect PACE
Revised	06/01/2019	EE.1127	Disposable Incontinence Supplies Network	Medi-Cal OneCare Connect PACE
Revised		EE.1127Δ	Disposable Incontinence Supplies Network	Medi-Cal OneCare OneCare Connect PACE

For 20201105 BOD Review Only

IX. GLOSSARY

Term	Definition
Grievance	Medi-Cal: A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by the MCP to make an authorization decision. Also a Complaint from a Member related to Medi-Cal benefits and services pursuant to Welfare and Institutions Code Section 14450 and California Health and Safety Code Section 1368 and 1368.1. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. OneCare Connect: Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint." PACE: A complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of Participant care. A Grievance may include, but is not limited to: 1. The quality of services a Participant receives in the home, at the PACE Center or in an inpatient stay (hospital, rehabilitative facility, skilled nursing facility, intermediate care facility or residential care facility); 2. Waiting times on the telephone, in the waiting room or exam room; 3. Behavior of any of the care providers or PACE staff members; 4. Adequacy of center facilities; 5. Quality of the food provided; 6. Transportation services; and 7. A violation of a Participant's rights.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a CalOptima program.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.

For 20201105 BOD Review Only

Policy: EE.1135
Title: **Long Term Care Facility Contracting**
Department: Contracting
Section: Not Applicable

CEO Approval:

Effective Date: 01/01/2004
Revised Date: ~~04/04/2019~~

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

~~*Board Approved Policy*~~

For 20201105 BOD Review Only

I. PURPOSE

This policy establishes CalOptima's contracting and Letter of Agreement (LOA~~)~~*) requirements for Long Term Care (LTC) Facilities.

II. POLICY

A. CalOptima only contracts with, and reimburses, Facilities that are licensed and certified by the California Department of Public Health (CDPH) and approved by the Department of Health Care Services (DHCS) for participation in the Medi-Cal program.

1. CalOptima shall include all Facilities within the Service Area that meet the requirements of Section II.A. of this Policy in the provider network to the extent that the Facility remains licensed, certified, operating, meets CalOptima's credentialing and quality standards, and is willing to enter into a contract with CalOptima on mutually agreeable terms.

2. If CalOptima determines that a Member's need for Facility services exceeds the capacity of those currently contracted, CalOptima shall arrange access to out-of-network Facilities.

3. CalOptima shall notify DHCS if it is unable to come to agreeable terms with a Facility meeting the requirements in Section II.A of this Policy, or upon termination of a Facility contract in accordance with Section III.D of this Policy, and as required by DHCS.

B. CalOptima shall require credentialing of all contracted Facilities, in accordance with CalOptima Policy GG.1651Δ: ~~Credentialing and Recredentialing of Healthcare Delivery Organizations~~Assessment and Re-Assessment of Organizational Providers, prior to the execution of a contract.

C. CalOptima completes LOAs with, and reimburses, non-contracted Facilities that are licensed and certified by CDPH and approved by the DHCS for participation in the Medi-Cal program. An LOA is initiated when:

1. CalOptima places a Member in a non-contracted Facility;

2. CalOptima is notified by a non-contracted Facility, an acute hospital, the Member, Member's Personal Representative, or a Health Network that;

a. A Member has been placed in a non-contracted Facility;

Back to Agenda Back to Item

b. A resident in a non-contracted Facility has or will become newly enrolled into CalOptima; or

c. A Member that resides in the non-contracted Facility under their Medicare benefit, has exhausted or will soon exhaust their Medicare benefit.

D. Upon identifying a need for an LOA or contract with a Facility, the CalOptima Director of Contracting or authorized Designee shall initiate the Facility contracting process in accordance with the provisions of Sections II.C, III.B, and III.C of this Policy.

E. Only a Facility that holds a contract or LOA with CalOptima as described in this Policy is eligible to receive reimbursement for Covered Services furnished to a Member within that Facility.

F. If a non-contracted Facility admits a Member, the non-contracted Facility shall contact CalOptima Long Term Services and Support Department (LTSS) Department to initiate the LOA process in accordance with the terms and conditions set forth in Sections II.C, III.B, and III.C of this Policy.

G. If a Facility executes a contract or LOA with CalOptima, CalOptima may retrospectively reimburse the Facility up to one (1) year from the date of the execution of the contract or LOA. A Facility is eligible to receive such retrospective reimbursement if:

1. The Facility submits an Authorization Request Form (ARF) to the LTSS Department within twenty-one (21) calendar days from the date of execution of the contract or LOA, or submits time-stamped evidence to the LTSS Department that an ARF was submitted to their department;

2. The Member meets the clinical criteria for Covered Services at the time of admission; and

3. The ARF would have been approved, but for the absence of the contract or LOA.

H. CalOptima shall provide a Member with access to the names of contracted Facilities in the Provider Directory, through the CalOptima website's Ancillary and Facility Search Tool, and upon the Member's request for such information.

I. If a Member is admitted to a Facility under the Medicare benefit, CalOptima shall reimburse a Facility, regardless of contract status, for a Member's Medicare coinsurance from the Member's twentieth (20th) day and through the one hundredth (100th) day.

III. PROCEDURE

A. The CalOptima Contracting Department oversees and manages the Facility contracting process, in collaboration with the CalOptima LTSS and Claims Department, to ensure appropriate payment for Covered Services.

B. For a New Admission to a non-contracted Facility located within Orange County for which CalOptima's LTSS Department has been notified, the CalOptima Contracting Department shall:

1. Provide a contract to the non-contracted Facility for review and approval via e-mail as a PDF document, upon notification from CalOptima's Quality Improvement Department that the Facility has been successfully credentialed; and

2. Complete LOAs for Member admissions while the Facility's credentialing is in process.

For 20201105 BOD Review Only

C. For a New Admission to a non-contracted Facility located outside of Orange County, for which CalOptima's LTSS Department has been notified, the CalOptima Contracting Department shall:

1. Notify the non-contracted Facility that an LOA with CalOptima is required to be eligible to receive reimbursement for Covered Services furnished to a Member in such LTC Facility.

2. Execute an LOA for one (1) year with the non-contracted Facility, upon written request of the LTSS Director or authorized Designee.

   a. Except for a Member who is under conservatorship (including with the Office of the Public Guardian) or has a Personal Representative residing in Orange County, the Facility's staff shall actively work with the Member or Member's representative to transfer the Member's Medi-Cal eligibility to the county of residence during the time frame of the LOA. CalOptima's LTSS Department shall follow up with Facility on a monthly basis to ensure they are actively working to transfer Member's Medi-Cal eligibility to the county of residence.

   b. If a Member is residing in a Facility outside of Orange County longer than the LOA time frame, and the Member's Medi-Cal eligibility has not been transferred to the county of residence, the Facility shall notify the CalOptima LTSS Department prior to the LOA expiration date. The CalOptima LTSS Department shall submit a request to the CalOptima Contracting Department to initiate a new LOA for a one (1) year term.

   c. The CalOptima Contracting Department may complete an LOA with a non-contracted Facility outside of Orange County only upon the request of the LTSS Director or authorized Designee.

   d. The CalOptima Contracting Department may initiate a contract with a non-contracted Facility outside of Orange County when the Contracting Department has identified ten (10) or more LOAs for unique Members have been completed with the Facility over the past year, or at the request of the LTSS Director or authorized Designee.

   e. A Member who is under conservatorship (including with the Office of the Public Guardian) or has a Personal Representative residing in Orange County, may remain in a Facility outside of Orange County, if so requested. In which case, the LTSS Director or authorized Designee may authorize the CalOptima Contracting Department to extend a contract to the Facility.

D. Termination of Facility Contract

1. CalOptima shall notify DHCS upon termination of a Facility contract:

   a. If CalOptima and a Facility in the Service Area cannot agree on mutually agreeable terms, CalOptima shall notify the DHCS within five (5) working days of CalOptima's decision to exclude the Facility from its provider network.

   b. CalOptima shall provide the DHCS with notice of its termination of a contract with a Facility at least sixty (60) calendar days prior to the contract termination effective date.

      i. CalOptima shall not continue to assign or refer Members to a Facility during the sixty (60) calendar days between notifying the DHCS and the contract termination effective date.

For 20201105 BOD Review Only

c. If termination of a Facility contract is for a cause related to quality of care or patient safety concerns, CalOptima shall expedite termination of the Facility contract and transfer Members to an appropriate, qualified Facility in an expeditious manner. The DHCS shall be notified of the termination within seventy-two (72) hours of said termination.

2. CalOptima's Regulatory Affairs & Compliance Department shall notify the DHCS upon notification from the Contracting Department of any of the actions detailed in Section III.D.1 of this Policy, in accordance with CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

3. Affected Members shall be notified of the actions detailed Section III.D.1 of this Policy, as applicable, in accordance with CalOptima Policy DD.2012 Member Notification of Change in the Availability or Location of Covered Services.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services for Medi-Cal
B. CalOptima Policy DD.2012 Member Notification of Change in the Availability or Location of Covered Services
C. CalOptima Policy GG.1651Δ: ~~Credentialing and Recredentialing of Healthcare Delivery Organizations~~Assessment and Re-Assessment of Organizational Providers
D. CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
E. CalOptima Long Term Care Provider Resource Manual
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-004: Medical Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
H. Title 22, California Code of Regulations (CCR), Division 3
I. Title 22, California Code of Regulations (CCR), Sections ~~51215,~~ 51121, 51212, 51215, 51215.5, 51215.8, 51334, and 51335
J. Title 18, Federal Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
10/13/2015	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
04/04/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2004	GG.1825	Long Term Care Facility Contracting	Medi-Cal

For 2020 1105 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	05/01/2009	GG.1825	Long Term Care Facility Contracting	Medi-Cal
Revised	01/01/2010	EE.1135	Long Term Care Facility Contracting	Medi-Cal
Revised	07/01/2015	EE.1135	Long Term Care Facility Contracting	Medi-Cal
Revised	08/01/2016	EE.1135	Long Term Care Facility Contracting	Medi-Cal OneCare Connect
Revised	12/01/2017	EE.1135	Long Term Care Facility Contracting	Medi-Cal OneCare Connect
Revised	04/04/2019	EE.1135	Long Term Care Facility Contracting	Medi-Cal OneCare Connect
Revised		EE.1135	Long Term Care Facility Contracting	Medi-Cal OneCare Connect

1

For 20201105 BOD Review Only

IX. GLOSSARY

Term	Definition
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program~~,~~ (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301~~,~~), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with ~~Section 6840, which~~ section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program~~effective July 1, 2~~, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), ~~and~~ speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), ~~which~~ and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), ~~effective January 1, 2020~~ for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not~~-~~withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and ~~Centers for Medicare & Medicaid Services (~~CMS~~)~~. PACE: ~~Those items and services that CalOptima is obligated to provide to Members under the contracts with the DHCS and CMS~~For the purposes of this policy, defined as those medical services, equipment, or supplies that CalOptima is obligated to provide to Participants under the provisions of Welfare & Institutions Code section 14132 and the CalOptima PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Facility	Long Term Care (LTC) facility, including a Nursing Facility Level A (NF-A) [Intermediate Care Facility (ICF) or Subacute Facility] and Nursing Facility Level B (NF-B) [Skilled Nursing Facility (SNF)].

For 20201105 BOD Review Only

Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.
Member	~~An enrollee~~~~A Member~~ beneficiary enrolled in ~~of~~ a CalOptima program.
New Admission	Shall mean a Member with no previous residence history at a Facility or one who has had a previous residence history at a Facility but was appropriately discharged as part of the Member's plan of care.
Personal Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009Δ: Access by Member's Personal Representative.
Service Area	~~County of Orange, California.~~Medi-Cal: The county or counties that CalOptima is approved to operate in under the terms of the DHCS contract. Currently, this covers Orange County, California. OneCare: A geographic area that for CalOptima is a county or the multiple counties approved by CMS within which a OneCare eligible member may enroll in CalOptima OneCare. CalOptima OneCare must be available to all OneCare eligible individuals within the plan's service area. Currently, this covers Orange County, California. OneCare Connect: The county or counties that CalOptima is approved to operate in under the terms of CalOptima's contracts with DHCS and CMS. Currently, this covers Orange County, California. PACE: Geographical region comprised of those areas designated by the U.S Postal Service ZIP Codes that have been proposed by CalOptima and approved in the PACE Program Agreement to ensure adequate access to health care services by plan members who reside therein. Currently, this covers Orange County, California.
Working Days	Shall mean state of California working day(s).

For 2020 IC BOD Review Only

Policy: EE.1135
Title: **Long Term Care Facility Contracting**
Department: Contracting
Section: Not Applicable

CEO Approval:

Effective Date: 01/01/2004
Revised Date:

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

For 20201105 BOD Review Only

I. PURPOSE

This policy establishes CalOptima's contracting and Letter of Agreement (LOA) requirements for Long Term Care (LTC) Facilities.

II. POLICY

A. CalOptima only contracts with, and reimburses, Facilities that are licensed and certified by the California Department of Public Health (CDPH) and approved by the Department of Health Care Services (DHCS) for participation in the Medi-Cal program.

1. CalOptima shall include all Facilities within the Service Area that meet the requirements of Section II.A. of this Policy in the provider network to the extent that the Facility remains licensed, certified, operating, meets CalOptima's credentialing and quality standards, and is willing to enter into a contract with CalOptima on mutually agreeable terms.

2. If CalOptima determines that a Member's need for Facility services exceeds the capacity of those currently contracted, CalOptima shall arrange access to out-of-network Facilities.

3. CalOptima shall notify DHCS if it is unable to come to agreeable terms with a Facility meeting the requirements in Section II.A of this Policy, or upon termination of a Facility contract in accordance with Section III.D of this Policy, and as required by DHCS.

B. CalOptima shall require credentialing of all contracted Facilities, in accordance with CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers, prior to the execution of a contract.

C. CalOptima completes LOAs with, and reimburses, non-contracted Facilities that are licensed and certified by CDPH and approved by the DHCS for participation in the Medi-Cal program. An LOA is initiated when:

1. CalOptima places a Member in a non-contracted Facility;

2. CalOptima is notified by a non-contracted Facility, an acute hospital, the Member, Member's Personal Representative, or a Health Network that;

a. A Member has been placed in a non-contracted Facility;

Back to Agenda Back to Item

b. A resident in a non-contracted Facility has or will become newly enrolled into CalOptima; or

c. A Member that resides in the non-contracted Facility under their Medicare benefit, has exhausted or will soon exhaust their Medicare benefit.

D. Upon identifying a need for an LOA or contract with a Facility, the CalOptima Director of Contracting or authorized Designee shall initiate the Facility contracting process in accordance with the provisions of Sections II.C, III.B, and III.C of this Policy.

E. Only a Facility that holds a contract or LOA with CalOptima as described in this Policy is eligible to receive reimbursement for Covered Services furnished to a Member within that Facility.

F. If a non-contracted Facility admits a Member, the non-contracted Facility shall contact CalOptima Long Term Services and Support Department (LTSS) Department to initiate the LOA process in accordance with the terms and conditions set forth in Sections II.C, III.B, and III.C of this Policy.

G. If a Facility executes a contract or LOA with CalOptima, CalOptima may retrospectively reimburse the Facility up to one (1) year from the date of the execution of the contract or LOA. A Facility is eligible to receive such retrospective reimbursement if:

1. The Facility submits an Authorization Request Form (ARF) to the LTSS Department within twenty-one (21) calendar days from the date of execution of the contract or LOA, or submits time-stamped evidence to the LTSS Department that an ARF was submitted to their department;

2. The Member meets the clinical criteria for Covered Services at the time of admission; and

3. The ARF would have been approved, but for the absence of the contract or LOA.

H. CalOptima shall provide a Member with access to the names of contracted Facilities in the Provider Directory, through the CalOptima website's Ancillary and Facility Search Tool, and upon the Member's request for such information.

I. If a Member is admitted to a Facility under the Medicare benefit, CalOptima shall reimburse a Facility, regardless of contract status, for a Member's Medicare coinsurance from the Member's twentieth (20^{th}) day and through the one hundredth (100^{th}) day.

III. PROCEDURE

A. The CalOptima Contracting Department oversees and manages the Facility contracting process, in collaboration with the CalOptima LTSS and Claims Department, to ensure appropriate payment for Covered Services.

B. For a New Admission to a non-contracted Facility located within Orange County for which CalOptima's LTSS Department has been notified, the CalOptima Contracting Department shall:

1. Provide a contract to the non-contracted Facility for review and approval via e-mail as a PDF document, upon notification from CalOptima's Quality Improvement Department that the Facility has been successfully credentialed; and

2. Complete LOAs for Member admissions while the Facility's credentialing is in process.

C. For a New Admission to a non-contracted Facility located outside of Orange County, for which CalOptima's LTSS Department has been notified, the CalOptima Contracting Department shall:

For 20201105 BOD Review Only

1. Notify the non-contracted Facility that an LOA with CalOptima is required to be eligible to receive reimbursement for Covered Services furnished to a Member in such LTC Facility.

2. Execute an LOA for one (1) year with the non-contracted Facility, upon written request of the LTSS Director or authorized Designee.

    a. Except for a Member who is under conservatorship (including with the Office of the Public Guardian) or has a Personal Representative residing in Orange County, the Facility's staff shall actively work with the Member or Member's representative to transfer the Member's Medi-Cal eligibility to the county of residence during the time frame of the LOA. CalOptima's LTSS Department shall follow up with Facility on a monthly basis to ensure they are actively working to transfer Member's Medi-Cal eligibility to the county of residence.

    b. If a Member is residing in a Facility outside of Orange County longer than the LOA time frame, and the Member's Medi-Cal eligibility has not been transferred to the county of residence, the Facility shall notify the CalOptima LTSS Department prior to the LOA expiration date. The CalOptima LTSS Department shall submit a request to the CalOptima Contracting Department to initiate a new LOA for a one (1) year term.

    c. The CalOptima Contracting Department may complete an LOA with a non-contracted Facility outside of Orange County only upon the request of the LTSS Director or authorized Designee.

    d. The CalOptima Contracting Department may initiate a contract with a non-contracted Facility outside of Orange County when the Contracting Department has identified ten (10) or more LOAs for unique Members have been completed with the Facility over the past year, or at the request of the LTSS Director or authorized Designee.

    e. A Member who is under conservatorship (including with the Office of the Public Guardian) or has a Personal Representative residing in Orange County, may remain in a Facility outside of Orange County, if so requested. In which case, the LTSS Director or authorized Designee may authorize the CalOptima Contracting Department to extend a contract to the Facility.

D. Termination of Facility Contract

1. CalOptima shall notify DHCS upon termination of a Facility contract:

    a. If CalOptima and a Facility in the Service Area cannot agree on mutually agreeable terms, CalOptima shall notify the DHCS within five (5) working days of CalOptima's decision to exclude the Facility from its provider network.

    b. CalOptima shall provide the DHCS with notice of its termination of a contract with a Facility at least sixty (60) calendar days prior to the contract termination effective date.

        i. CalOptima shall not continue to assign or refer Members to a Facility during the sixty (60) calendar days between notifying the DHCS and the contract termination effective date.

    c. If termination of a Facility contract is for a cause related to quality of care or patient safety concerns, CalOptima shall expedite termination of the Facility contract and transfer

For 20201105 BOD Review Only

Members to an appropriate, qualified Facility in an expeditious manner. The DHCS shall be notified of the termination within seventy-two (72) hours of said termination.

2. CalOptima's Regulatory Affairs & Compliance Department shall notify the DHCS upon notification from the Contracting Department of any of the actions detailed in Section III.D.1 of this Policy, in accordance with CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

3. Affected Members shall be notified of the actions detailed Section III.D.1 of this Policy, as applicable, in accordance with CalOptima Policy DD.2012 Member Notification of Change in the Availability or Location of Covered Services.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services for Medi-Cal
B. CalOptima Policy DD.2012 Member Notification of Change in the Availability or Location of Covered Services
C. CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers
D. CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
E. CalOptima Long Term Care Provider Resource Manual
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-004: Medical Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
H. Title 22, California Code of Regulations (CCR), Division 3
I. Title 22, California Code of Regulations (CCR), Sections 51121, 51212, 51215, 51215.5, 51215.8, 51334, and 51335
J. Title 18, Federal Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
10/13/2015	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
04/04/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2004	GG.1825	Long Term Care Facility Contracting	Medi-Cal
Revised	05/01/2009	GG.1825	Long Term Care Facility Contracting	Medi-Cal
Revised	01/01/2010	EE.1135	Long Term Care Facility Contracting	Medi-Cal
Revised	07/01/2015	EE.1135	Long Term Care Facility Contracting	Medi-Cal

For 20201105 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	08/01/2016	EE.1135	Long Term Care Facility Contracting	Medi-Cal OneCare Connect
Revised	12/01/2017	EE.1135	Long Term Care Facility Contracting	Medi-Cal OneCare Connect
Revised	04/04/2019	EE.1135	Long Term Care Facility Contracting	Medi-Cal OneCare Connect
Revised		EE.1135	Long Term Care Facility Contracting	Medi-Cal OneCare Connect

1

For 20201105 BOD Review Only

IX. GLOSSARY

Term	Definition
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and CMS. PACE: For the purposes of this policy, defined as those medical services, equipment, or supplies that CalOptima is obligated to provide to Participants under the provisions of Welfare & Institutions Code section 14132 and the CalOptima PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Facility	Long Term Care (LTC) facility, including a Nursing Facility Level A (NF-A) [Intermediate Care Facility (ICF) or Subacute Facility] and Nursing Facility Level B (NF-B) [Skilled Nursing Facility (SNF)].
Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.
Member	A beneficiary enrolled in a CalOptima program.

For 20201105 BOD Review Only

New Admission	Shall mean a Member with no previous residence history at a Facility or one who has had a previous residence history at a Facility but was appropriately discharged as part of the Member's plan of care.
Personal Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009Δ: Access by Member's Personal Representative.
Service Area	Medi-Cal: The county or counties that CalOptima is approved to operate in under the terms of the DHCS contract. Currently, this covers Orange County, California. OneCare: A geographic area that for CalOptima is a county or the multiple counties approved by CMS within which a OneCare eligible member may enroll in CalOptima OneCare. CalOptima OneCare must be available to all OneCare eligible individuals within the plan's service area. Currently, this covers Orange County, California. OneCare Connect: The county or counties that CalOptima is approved to operate in under the terms of CalOptima's contracts with DHCS and CMS. Currently, this covers Orange County, California. PACE: Geographical region comprised of those areas designated by the U.S Postal Service ZIP Codes that have been proposed by CalOptima and approved in the PACE Program Agreement to ensure adequate access to health care services by plan members who reside therein. Currently, this covers Orange County, California.
Working Days	Shall mean state of California working day(s).

1

For 20201105 BOD Review Only

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contact

Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Action

Authorize amendment to the current Kaiser Foundation Health Plan, Inc. Health Network Contract to extend the current term through the date of the next CalOptima Board meeting, December 3, 2020.

Background

Kaiser Foundation Health Plan, Inc. (Kaiser) participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Kaiser's current Health Network Contract expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS-required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments.

CalOptima and Kaiser staff worked with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. To allow time for Kaiser and CalOptima to obtain all necessary information and final clarification from DHCS and complete discussions regarding the Amended and Restated Contract, the parties entered into an initial ninety (90) day extension of Kaiser's current contract through September 30, 2020. Due to the June 30, 2020 expiration date of the current Kaiser Health Network Contract, this extension was ratified by the Board on August 6, 2020. As of the last Board of Directors' Meeting, on October 1, 2020, it was determined that review of certain provisions in the Amended and Restated contract was still in progress. As such, an additional month-long extension was requested until November 5, 2020.

Discussion

The parties continue to review certain provisions of the Amended and Restated Contract that memorialize operational requirements in light of Kaiser's unique model as well as the five (5) subsequent amendments that implement Proposition 56, Health Homes Program requirements and other terms (Contract Amendments). Additionally, because Kaiser is the only CalOptima Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser staff are addressing terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract when the State implements its Medi-Cal Rx program effective January 1, 2021 including, revised rates and DHCS-mandated transition terms.

While CalOptima and Kaiser staff have attempted to complete all contract and amendment revisions by November 5, 2020, additional time is required to fully explore whether the parties will be able to resolve and finalize the remaining issues. Staff has requested an additional month-long extension of the current

Back to Agenda

Kaiser Contract on the same terms and conditions to complete the discussions and finalize the Amended and Restated Contract and Contract Amendments. Because Staff intends to present the final Kaiser Amended and Restated Contract and Contract Amendments to the Board for approval at the December 3, 2020 meeting, Staff requests that the Board approve extension of the current Kaiser Health Network Contract through that date.

Fiscal Impact

The recommended action to authorize extension of the current Kaiser Health Network Contract to through December 3, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

Amending the current Kaiser Health Network Contract to extend through December 3, 2020, the date of the Board's next meeting, under the same terms and conditions will allow the additional time needed to review and finalize Kaiser's FY 2020-21 Amended and Restated Health Network Contract.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated August 6, 2020; "Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract"
3. Previous Board Action dated October 1, 2020; "Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term.

/s/ Richard Sanchez — *10/28/2020*

Authorized Signature — **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

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

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

Recommended Actions
Ratify the amendment to the Kaiser Foundation Health Plan, Inc. (Kaiser) Health Network contract, extending the term through September 30, 2020.

Background/Discussion
Kaiser participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Each of CalOptima's contracts with its 12 twelve Medi-Cal Health Networks, including Kaiser, include a provision permitting an annual one-year extension of the contract subject to CalOptima Board of Directors' approval and signed contract amendments. Kaiser's current Health Network Contract ("Kaiser Contract") expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments. Kaiser has not, however, executed the Amended and Restated Contract. CalOptima and Kaiser have been working with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. The parties have also been reviewing certain contract provisions that memorialize operational requirements in light of Kaiser's unique staff model.

In order to allow time for Kaiser and CalOptima to obtain final clarification from DHCS and finalize discussions with Kaiser, the parties entered into a ninety (90) day extension of the Kaiser Contract through September 30, 2020, subject to Board approval. Additionally, because Kaiser is the only Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser also need to address contract terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract. The pharmacy benefit carve-out will be effective January 1, 2021 for all Managed Care Plans, including CalOptima.

Staff recommends ratification of the Kaiser Contract amendment to provide additional time to obtain DHCS's final guidance, and for the parties to reach agreement on the Amended and Restated Contract terms.

Fiscal Impact
The recommended action to ratify the amendment to the Kaiser Contract to extend the term through September 30, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima FY 2020-21 Operating Budget approved by the Board on June 4, 2020.

Back to Agenda Back to Item

Rationale for Recommendation

This extension will allow additional time to review and finalize Kaiser's FY 2020-21 Health Network contract.

.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action Dated June 4, 2020; "Authorize Extension and Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contracts with Kaiser Permanente

/s/ Richard Sanchez *07/29/2020*

Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Michelle Laughlin, Executive Director Network Operations (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Medi-Cal Full-Risk Health Network HMO, Shared-Risk, and Physician-Hospital Consortium Health Network contracts to:

1. Extend the term through June 30, 2021;
2. Reflect adjustments in Health Network's capitation rates and add language reflecting that Directed Payments will be made pursuant to CalOptima Policy and Procedures effective July 1, 2020; and
3. Revise the Shared Risk program attachment in the Shared Risk group contracts to align with changes made to Policy FF.1010 related to the description of the Shared Risk budget.

Background/Discussion

CalOptima currently contracts with 12 health networks to provide care to CalOptima Medi-Cal members. The continued renewal of the contracts will support the stability of CalOptima's contracted provider network. CalOptima's current Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts listed below will expire on June 30, 2020:

Full Risk HMO:
Heritage Provider Network, Inc.
Kaiser Foundation Health Plan, Inc.
Monarch Health Plan, Inc.
Prospect Health Plan, Inc.

Shared Risk:
AltaMed Health Services Corporation
ARTA Western California, Inc.
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates Inc. of Mid Orange County
Talbert Medical Group, P.C.
United Care Medical Group, Inc.

Physician-Hospital Consortium:
CHOC Physician's Network and Children's Hospital of Orange County
AMVI Care Health Network and Fountain Valley Regional Hospital and Medical Center
Family Choice Medical Group, Inc. and Fountain Valley Regional Hospital and Medical Center

Back to Agenda Back to Item

Staff recommends extending the above Health Network contracts for one year, through June 30, 2021. Extension of the Heath Network contracts is essential to ensuring that members assigned to health networks have access to covered healthcare services.

Health Network Capitation Rate Adjustment

Medi-Cal Classic Rebasing: For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Classic capitation rates effective July 1, 2020, following CalOptima's periodic rebasing process. Rebasing ensures capitation rates paid to our Health Network providers include appropriate reimbursement for medical and non-medical expenses.

Medi-Cal Expansion (MCE) Rates: In 2014, Medi-Cal eligibility was expanded to cover single, low-income individuals ages 19-64, known as Medi-Cal Expansion (MCE). The Department of Health Care Services (DHCS) provided additional funding to support newly eligible MCE members, a group separate from the Medi-Cal Classic member population. Due to the absence of any utilization information at the program's inception, capitation rates for MCE members were set based on assumed population risk from the beginning of the expansion to date.

For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Expansion (MCE) capitation rates effective July 1, 2020. DHCS has applied multiple downward adjustments to CalOptima's MCE capitation rates due to a lower average acuity than first anticipated. As such, staff continues to analyze the appropriateness of MCE capitation rates paid to Health Networks. Based on an actuarial analysis of utilization data, additional reductions to MCE capitation rates are appropriate.

Over the course of the program, sufficient time has passed to compile reliable Chronic Disability Payment System (CDPS) diagnostic information necessary for risk adjustment. With the CDPS information now available to make determinations regarding acuity, staff proposes to amend the current Health Network contracts to adjust the MCE rate, either up or down, based on CDPS data. With margins being reduced, it is more important to implement risk adjustment to ensure capitation payments are commensurate with population acuity. Staff has provided notices to the Health Networks that their MCE capitation rate will be risk adjusted starting July 1, 2020.

OB Kick Payment Rate Increase: Per Policy FF.1005f, CalOptima has historically provided all Health Networks a supplemental payment for qualifying covered obstetric delivery services. The current rates, set in 2010 when the Maternity Kick Payment program began, are $793 for professional services and $4,451 for facility fees. For the new contract term, staff recommends authorization to increase these rates to $900 for professional services and $5,000 for facility fees for all Health Networks, with the exception of Kaiser Health Plan, Inc. which is being reimbursed according to the terms set forth in a March 7, 2019 Board Action.

Directed Payments

Periodically CalOptima is required through DHCS or CMS guidance to make statutorily mandated retrospective payments to its Health Networks. These payments are typically based on DHCS programs, including Proposition 56 and the Quality Assurance Fee (QAF) supplemental payments. In many cases these provider supplemental payments have been established and administered over multiple time periods and phases, sometimes across multiple years retrospectively, and often based on actual claims paid. Until now, CalOptima has made these DHCS- and CMS- defined supplemental payments to its health networks via contract amendment, as notification came down from the state or federal government. Given the ongoing nature of these payments – including those given under Proposition 56 - multiple amendments, retroactive contract terms, and subsequent timeliness concerns for payment to the impacted providers have been ongoing concerns. To mitigate this, staff recommends that moving forward, Directed Payments be administered according Policy & Procedure FF. 2011 ("Directed Payments"), which addresses Directed Payment programs listed below. Directed Payment is an add-on payment or minimum fee payment required by DHCS to be made to eligible providers for qualifying services (identified below) with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments. As an alternative to requesting authority to amend these contracts on each individual occasion, Policy FF.2011 directs CalOptima to reimburse Health Networks for Direct Payments as they are mandated, pursuant to qualifying services being rendered, providing both policy and procedure guidelines.

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance
Physician Services	7/1/2017 to 12/31/2020	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
Ground Emergency Medical Transport (GEMT)*	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 APL 20-002 released January 31, 2020

**Directed Payments for GEMT Services are not applicable to Shared-Risk Group*

Staff anticipates that Policy FF.2011 will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Shared Risk Pool Revisions
Pursuant to a separate Board action, Staff has revised CalOptima Policy FF.1010: Shared Risk Pool to clarify language regarding the Shared Risk pool budget in relation to Coordination of Benefits (COB) recoveries. This revision clarifies that:

1) COB recoveries reduce expense but do not increase revenue; and

2) Since CalOptima is self-insured, reinsurance premium will no longer be allocated to the risk pool.

Fiscal Impact
The recommended actions to enter into amended Medi-Cal Health Network contracts to extend through June 30, 2021, add language reflecting changes to how the Directed Payments are handled, and align Shared Risk group contracts with revisions to CalOptima Policy FF.1010 are not expected to have a fiscal impact.

Costs associated with the recommended action to adjust capitation rates for these contracts, with the exception of Kaiser Foundation Health Plan, Inc., have been included in the proposed CalOptima Fiscal Year (FY) 2020-21 Operating Budget pending Board approval. These proposed changes represent an approximately 2.0% overall reduction in Medi-Cal Classic health network capitation payments, projected at an estimated $8 million in FY 2020-21. In addition, the budget proposes an overall reduction of 7% to the MCE Professional capitation rate and a reduction of 14% to the MCE Hospital capitation rate. Aggregate decreases to MCE Professional capitation expenses and associated shared risk pools are projected to be $50 million in FY 2020-21.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Action
2. Previous Board Action dated June 6, 2019, Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates
3. Previous Board Action dated December 6, 2018, Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole Child Model Implementation Date
4. Previous Board Action dated April 2, 2020, Consider Approval of CalOptima Medi-Cal Directed Payments Policy

5. Policy & Procedure FF.2011: Directed Payments
6. Policy & Procedure FF.1005f: Special Payments: Supplemental OB Delivery Care Payment
7. Previous Board Action dated March 7, 2013, Authorize and Direct Chief Executive Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan, (Kaiser)

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

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 E Walnut St.	Pasadena	CA	91188
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	10855 Business Center Dr. Ste. C	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into Amended and Restated Full Risk Health Network Contracts with Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. effective July 1, 2019 date that address the following:

a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements;
b) Amended capitation rates for assigned members effective July 1, 2019 to the extent authorized by the Board in a separate Board action;

Background/Discussion

On December 6, 2018, the Board authorized extension of CalOptima's Medi-Cal Health Network contracts to June 30, 2020. In the interim, there have been numerous initiatives, APLs, and other regulatory updates which necessitate the revision of contract terms. Additionally, the Health Network contracts have been amended numerous times over the years reflecting program, compensation and/or regulatory changes and these changes need to be incorporated in a master template contract. At this time, Staff requests authority to issue an amended and restated Health Network contract incorporating previously approved amendments, changes to address regulatory guidance and amended capitation rates.

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with Health Networks. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in network provider contracts to meet state and federal contracting requirements.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions which include, but are not limited to:

Back to Agenda Back to Item

emergency services notification requirements; Government Claims Act specifications; and, document and data submissions certification obligations.

The budget for Fiscal Year (FY) 2019-20 reflects a decrease in Medi-Cal Expansion (MCE) revenue and an increase in Medi-Cal classic. Capitation reimbursement levels paid by CalOptima to providers for the MCE population is higher than levels that are supported by cost and utilization data. This fact coupled with the reduction in revenue from DHCS has resulted in decreases to the MCE capitation rates for the Health Networks. For the Medi-Cal Classic population Staff recommends an increase to both Professional and Hospital capitation for Adult TANF and SPD members. The amended and restated contract reflects revised capitation rates effective July 1, 2019 to the extent authorized by the Board in a separate Board action.

Fiscal Impact

The recommended action to enter into amended and restated Medi-Cal Health Network contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

Costs associated with the recommended action to revise capitation rates for these contracts have been included in the proposed CalOptima FY 2019-20 Operating Budget pending Board approval. The budget includes proposed increases of 4% to the Adult Temporary Assistance for Needy Families (TANF) and seniors and persons with disabilities (SPD) Professional capitation rates and 6% to the Adult TANF and SPD Hospital capitation rates. The increases total approximately $7.5 million in FY 2019-20.

In addition, the budget proposes a reduction of 8% to the MCE Professional capitation rate and a reduction of 21% to the MCE Hospital capitation rate. Aggregate decreases to MCE capitation expenses and associated shared risk pools are projected to be $95 million in FY 2019-20.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. All Plan Letter APL 19-001
3. Board Action Dated December 6, 2018, authorizing the extension of CalOptima Medi-Cal Health Network Contracts

/s/ Michael Schrader — *5/29/2019*

Authorized Signature — **Date**

Contracted Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip code
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).[1]

BACKGROUND:
In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).[2] The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.[3] In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to "Subcontracts" into compliance with the new and more stringent federal requirements.[4] As of now, and consistent with historical practice and Title 22 of the California Code of

[1] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rgn=div5
[2] See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[3] See 42 CFR 438.2, "Definitions."
[4] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4410
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

Back to Agenda Back to Item

Regulations (CCR) Section 53250,[5] DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.[6]

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.[7]

POLICY:

I. **Required Characteristics of Network Providers**
Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,[8] the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

---

[5] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[6] The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."
[7] The DHCS directed payment web page is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx
[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

ALL PLAN LETTER 19-001
Attachment A

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867.[1]
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

[1] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

7	Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.
8	Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights: a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees. b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California. c) In a form maintained in accordance with the general standards applicable to such book or record keeping. d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. e) Including all Encounter Data for a period of at least ten (10) years. f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time. g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).

9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.
10	Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider: a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.
12	Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.
13	Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.
14	Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.
15	Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.

16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.
17	Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.
18	Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.
21	Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

Back to Agenda Back to Item

To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

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

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

Rev. 6/7/2018

        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background
The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

Back to Agenda Back to Item

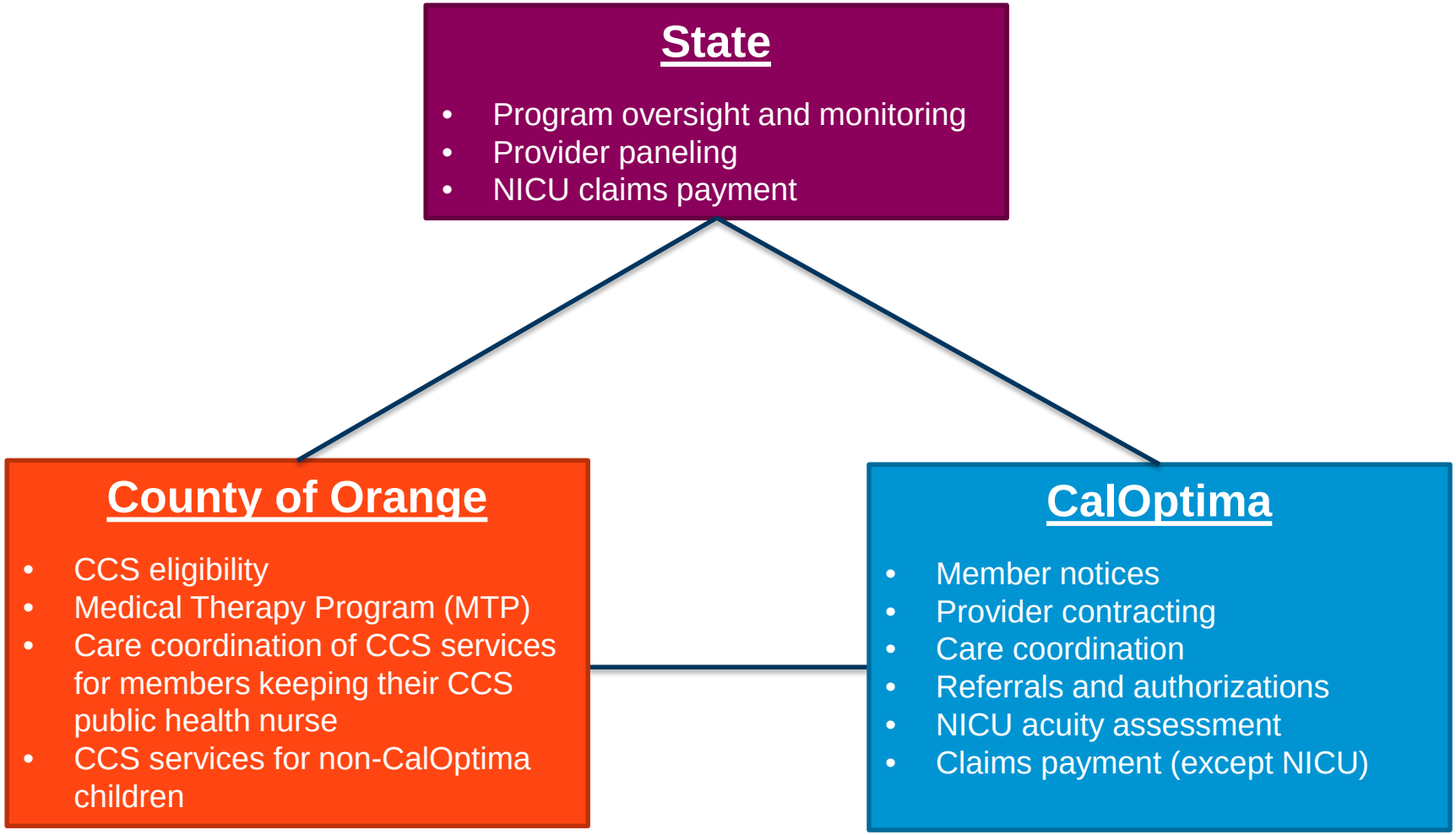
Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency

- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

Rev. 11/2/2017

Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

Rev. 11/2/2017

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

DRAFT

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

DRAFT

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

DRAFT

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

DRAFT

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

DRAFT

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

DRAFT

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

DRAFT

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

Back to Agenda Back to Item

Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature _____ **Date** _____

Print Name _____

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

Back to Agenda Back to Item

CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

Back to Agenda Back to Item

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

Back to Agenda Back to Item

CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

Back to Agenda Back to Item

To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

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

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

Rev. 6/7/2018

        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background
The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

Back to Agenda Back to Item

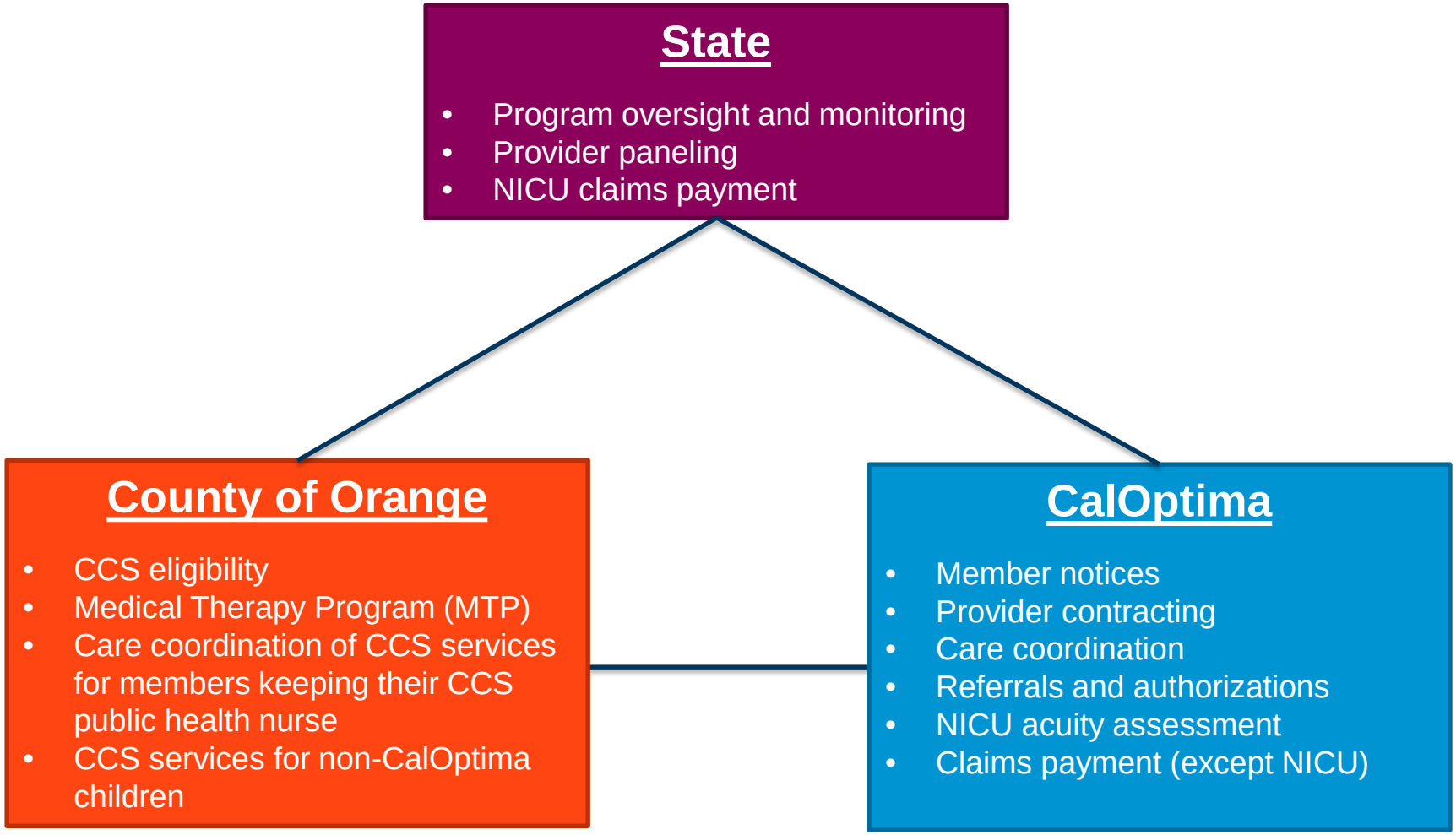
Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency

- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

Rev. 11/2/2017

Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

Rev. 11/2/2017

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

DRAFT

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

DRAFT

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

DRAFT

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

DRAFT

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

DRAFT

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

DRAFT

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

DRAFT

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

Back to Agenda Back to Item

Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature _____ **Date** _____

Print Name _____

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

Back to Agenda Back to Item

CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

Back to Agenda Back to Item

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

Back to Agenda Back to Item

CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Approval of CalOptima Medi-Cal Directed Payments Policy

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions

That the Board of Directors:

1. Approve CalOptima Medi-Cal Policy FF.2011 Directed Payments to align with current operational processes and comply with the Department of Health Care Services (DHCS) Directed Payment programs guidance.

2. Authorize the advance funding of the Directed Payments, as necessary and appropriate, for the Directed Payment programs identified in CalOptima Policy FF.2011.

3. Authorize the Chief Executive Officer, to approve as necessary and appropriate, the continuation of payment of Directed Payments to eligible providers for qualifying services before the release of DHCS final guidance, if instructed, in writing, by DHCS, and the State Plan Amendment (SPA) has been filed with the Centers for Medicare & Medicaid Services (CMS) for an extension of the Directed Payment program identified in CalOptima Policy FF.2011.

4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to update and amend, as necessary and appropriate, Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima.

Background/Discussion

DHCS has implemented Directed Payment programs aimed at specified expenditures for existing health care services through different funding mechanisms. The current DHCS Directed Payments programs are funded by the Quality Assurance Fee (QAF) and Proposition 56. DHCS operationalizes these Directed Payments programs by either adjusting the existing Medi-Cal fee Schedule by establishing a minimum fee schedule payment or through a specific add-on (supplemental) payment administered by the Medi-Cal Managed Care Plans (MCPs). DHCS releases Directed Payments guidance to the MCPs through All Plan Letters (APLs). The APLs include guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

CalOptima has established processes to meet regulatory timeliness and payment requirements for Proposition 56 physician payments and GEMT for the delegated health networks. On June 7, 2018 the CalOptima Board of Directors (Board) approved the methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers and services rendered for dates of service (DOS) in SFY 2017-18. On June 6, 2019, the Board ratified implementation of the standardized annual

Proposition 56 provider payment process for physician services extended into future DOS. On September 5, 2019, the Board approved the implementation of the statutorily mandated rate increase for GEMT. While staff initially planned for these initial directed payment initiatives to be time limited, additional directed payment provisions are anticipated and expected to be on-going. DHCS has also released information for additional Directed Payments programs to be implemented. The existing and new Directed Payment programs are as follows:

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance as of December 26, 2019
Physician Services	7/1/2017 to 12/31/2021	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
GEMT	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 State Plan Amendment: 19-0020 released 09/06/2019 APL 20-002 released January 31, 2020

In order to meet timeliness and payment requirements, CalOptima staff recommends establishing Medi-Cal policy FF.2011 Directed Payments, which addresses the above-listed qualifying services. This new policy defines Directed Payments and outlines the process by which a Health Network will follow DHCS guidelines regarding qualifying services, eligible providers, and payment requirements for applicable DOS. The policy establishes new reimbursement processes for Directed Payments not included in the Health Network capitation and reimbursed to the Health Network on a per service basis as well as a 2% administrative fee component. In addition, the policy provides an initial monthly payment to the Health Network for estimated medical costs that will be reconciled with the monthly reimbursement reports. This process will apply to qualifying services and eligible providers as prescribed through an APL or specified by DHCS through other correspondence.

Staff seeks authority to update and amend Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima. In the future, staff also anticipates that this policy will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Staff seeks authority to implement funding for Directed Payment programs identified in CalOptima Policy FF.2011 before it receives funding from DHCS. As of March 2020, CalOptima has not received funding from DHCS for the new Proposition 56 programs for developmental screening services and adverse childhood experiences (ACE) screening services, as well as the existing Directed Payment

program for GEMT services for SFY 2019-20 which includes two (2) new CPT codes. Implementation of directed payments before DHCS has issued funding are necessary as DHCS final APLs have already been issued.

Operational policies for CalOptima Direct, including the CalOptima Community Network, will be modified separately. CalOptima staff will seek CalOptima Board of Directors (Board) ratification action as required.

Fiscal Impact
The recommended action to approve CalOptima Policy FF.2011 are projected to be budget neutral to CalOptima. Staff anticipates funding provided by DHCS will be sufficient to cover the costs related to Directed Payment programs. As DHCS releases additional guidance and performs payment reconciliation, including application of risk corridors, Staff will closely monitor the potential fiscal impact to CalOptima.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with regulatory guidance provided by DHCS.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Board Action
2. CalOptima Policy FF.2011: Directed Payments [Medi-Cal]
3. Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
4. Board Action dated June 6, 2019, Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process
5. Board Action dated September 5, 2019, Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

Policy:	FF.2011
Title:	Directed Payments
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

For 20200402 BOD Review Only

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

Back to Agenda Back to Item

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any

For 20200402 BOD Review Only

administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday;

         2) After the first birthday and before or on the second birthday; or

For 20200402 BOD Review Only

3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

For 20200402 BOD Review Only

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall

For 20200402 BOD Review Only

ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

For 20200402 BOD Review Only

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

For 20200402 BOD Review Only

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

For 20200402 BOD Review Only

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

For 20200402 BOD Review Only

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

For 20200402 BOD Review Only

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

For 20200402 BOD Review Only

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

For 20200402 BOD Review Only

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

For 20200402 BOD Review Only

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

For 20200402 BOD Review Only

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2021

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/21
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

For 20200402 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[1]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[1]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

For 20200402 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[2]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[2]*Payment obligations for rates of at least $29 for eligible service codes*

For 20200402 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee Payment[3]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

[3]*Payment obligations for rates of at least $400 and $700 for eligible service codes*

For 20200402 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[4]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[4]Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes

For 20200402 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
8. Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
Ratify standardized annual Proposition 56 provider payment process.

Background
Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance is not provided until after the fiscal year begins. For example, Proposition 56 guidance for SFY 2017-18 was received on May 1, 2018, ten months after the start of the fiscal year. Thus, MCPs are required to make a one-time retroactive payment adjustment to catch-up for dates of service (DOS) from the beginning of the SFY to the catch-up date. Once the initial catch-up payments are distributed, future payments are made within the timeframe specific in the APL.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. In September 2018 DHCS instructed MCPs to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance has not been released as of May 28, 2019.

Discussion
In order to meet timeliness requirements for Proposition 56 payments each SFY and anticipating that requirements will continue to be released by APL or directly by DHCS, CalOptima staff recommends establishing a standardized annual process for Proposition 56 payment distributions. Ratification of this process is requested since CalOptima is required to distribute initial SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019, even though the final APL for the current fiscal year has not been released. The standardized process will apply to covered Medi-Cal Proposition 56 benefits administered directly by CalOptima (CalOptima Community Network or CalOptima Direct), or a

delegated health network. To comply with the annual Proposition requirements, CalOptima staff recommends utilizing the current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the receipt of initial payment from DHCS for the Proposition 56 designated SFY, CalOptima recommends an initial catch-up payment, if required, for eligible services between the beginning of the SFY to the current date, unless otherwise defined by DHCS. To process the initial catch-up payment, historical claims and encounter data will be utilized to identify the additional payments retroactively. Initial payments will be distributed no later than the timeliness requirements as defined in the APL. Similar to the previous process utilized, the following is recommended for each annual initial catch up payment:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims and encounters submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS.

- Health networks: Health network to utilize claims and encounter data to identify and appropriately pay providers retroactively for eligible services submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS. CalOptima will prefund the health network for estimated medical costs. Health network will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the prefunded medical costs, negative and positive, will be reconciled towards future Proposition 56 reimbursements. In addition, a 2% administrative component based on total medical costs will be remitted to the health network.

Ongoing Processing

Once the initial payment is distributed, future Proposition 56 provider payments must be made within the timeframe as defined in the Proposition 56 APL for eligible clean claims or adjusted encounters. The following is recommended for ongoing processing provided that CalOptima continues to receive funding for Proposition 56:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima will pay providers within the timeframe as defined by DHCS as claims or encounters are received.

- Health networks: Health network will pay providers within the timeframe defined by DHCS as claims or encounters are received. Concurrently, health network will be required to submit provider payment confirmation reports on a monthly basis that eligible Proposition 56 claims and encounter payments were issued timely. Reports will be due within 10 calendar days of the

end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component. Health networks will be required to report any recouped or refunded Proposition 56 payments received from providers. CalOptima will reconcile negative Proposition 56 medical and administrative payment adjustments towards future Proposition 56 reimbursements.

CalOptima, health networks will be expected to meet all reporting requirements as defined in the Proposition 56 APL or specifically requested by DHCS. Current processes will be used for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with all regulatory requirements and CalOptima's expectations related to Proposition 56. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. CalOptima staff will return to the Board for further approval if any future DHCS Proposition 56 requirements warrant significant changes to the proposed process. Additionally, should implementation of Proposition 56 require modifications to current health network, vendor, or provider contracts, CalOptima staff will seek separate Board action to the extent required.

Fiscal Impact
The recommended action to ratify the standardized annual Proposition 56 provider payment process is projected to be budget neutral to CalOptima. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount as the Proposition 56 funding provided by DHCS annually, resulting in a budget neutral impact to CalOptima's operating income.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

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

Attachment
June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

Back to Agenda Back to Item

Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

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

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

Back to Agenda Back to Item

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

Back to Agenda Back to Item

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

Conditions of Use | Privacy Policy
Copyright © 2007 State of California

Server:files.medi-cal.ca.gov |File:/pubsdoco/newsroom/newsroom_27057.asp |Last Modified:9/21/2018 5:14:04 PM

Policy:	FF.2011
Title:	**Directed Payments**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	*/s/ Richard Sanchez 04/15/2020*
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

Back to Agenda Back to Item

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

   a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

   a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

   b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

    a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

    b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

    a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

    a. The following Developmental Screening Services are eligible for an Add-On Payment:

        i. A routine screening when provided:

            1) On or before the first birthday;

            2) After the first birthday and before or on the second birthday; or

            3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health

Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/10/2020	Department of Health Care Services (DHCS) [file and use]

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Policy:	FF.1005f
Title:	**Special Payments: Supplemental OB Delivery Care Payment**
Department:	Finance
Section:	Not Applicable
CEO Approval:	/s/ *Michael Schrader 08/08/2019*
Effective Date:	01/01/2010
Revised Date:	07/01/2019

I. PURPOSE

This policy defines the criteria for a **Health Network***, with the exception of Kaiser Foundation Health Plan, Inc. (Kaiser), to receive a supplemental obstetrical (OB) delivery care payment for qualifying **Covered Services** provided to a **Member** enrolled in Medi-Cal for dates of service on and after January 1, 2010, in accordance with this policy.

II. POLICY

A. Effective for dates of service on and after January 1, 2010, CalOptima shall make a supplemental payment for qualifying **Covered Services** that include OB delivery care at a rate set forth in the **Contract for Health Care Services**, in accordance with the terms and conditions of this Policy.

B. A **Health Network** shall qualify for the supplemental payment for **Covered Services** that include OB delivery care if:

1. On the date of delivery, the **Member** was eligible with CalOptima for less than six (6) consecutive months;

2. On the date of delivery, the **Member** was between fifteen (15) and forty-four (44) years of age;

3. For the physician supplemental OB delivery care payment, **Covered Services** include physician services for normal and C-section delivery and assistant surgeon services billed with any of the following Current Procedural Terminology (CPT) codes: 59400, 59409, 59510, 59514, 59610, 59612, 59618, 59620; and modifier codes AG, or 80, as applicable;

4. For the hospital supplemental OB delivery care payment, **Covered Services** include hospital inpatient services related to an obstetric stay billed with the following Revenue Codes: 720, 721, 722, or 729;

5. The **Health Network** reimbursed the **Provider** for the **Covered Service**;

6. The **Health Network** authorized such services; and

7. The **Health Network** submits **Encounter** data in accordance with Section III.A of this policy.

C. If a **Health Network** identifies an **Overpayment** of a supplemental OB delivery care payment, the **Health Network** shall return the **Overpayment** within sixty (60) calendar days after the date on which the **Overpayment** was identified, and shall notify CalOptima's Accounting Department, in writing, of the reason for the **Overpayment**. CalOptima shall coordinate with the **Health Network** on the process to return the **Overpayment**.

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

Back to Agenda Back to Item

III. PROCEDURE

A. **Encounter** Data Submission

1. A **Health Network** shall report an **Encounter** in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such **Encounter**.

2. CalOptima shall qualify **Health Network Encounter** Data for valid CPT and Revenue codes, and report the valid **Encounters** for payment authorization.

B. A **Health Network** shall instruct a **Provider** to utilize the appropriate CPT and Revenue codes to bill for **Covered Services** provided to a **Member**.

C. Processing of Physician Claims

1. A **Health Network** shall process an eligible claim submitted by a **Provider** for physician services at a rate set forth in their contractual agreement.

2. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

D. Processing of Hospital Claims

1. **Physician Hospital Consortium (PHC)** or **Health Maintenance Organization (HMO)**

a. A **PHC** or **HMO** shall process an eligible claim submitted by a **Provider** for hospital inpatient services related to an obstetrical stay at a rate set forth in their contractual agreement.

b. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

2. Shared Risk Group (SRG)

a. CalOptima shall process a claim for hospital inpatient services related to an obstetrical stay provided to a **Member** enrolled in an **SRG** in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a **Shared Risk Group.**

b. CalOptima shall make a supplemental payment funding adjustment to the Shared Risk Pool in accordance with Section III.E.1 of this Policy.

E. Hospital Supplemental OB Delivery Care Payment

1. **SRG**: CalOptima shall make a supplemental payment funding adjustment to a Shared Risk Pool at a rate set forth in the **Contract for Health Care Services** for a covered hospital inpatient obstetrical delivery based on actual claims paid in accordance with CalOptima Policy FF.1010: Shared Risk Pool.

2. **PHC** or **HMO**: CalOptima shall make a supplemental payment at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

F. Physician Supplemental OB Delivery Care Payment

1. CalOptima shall make a supplemental payment to a **Health Network** for physician services for normal and C-section delivery and assistant surgeon services at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

G. With the exception of payment funding adjustment to a Shared Risk Pool described in Section III.E.1 of this Policy, CalOptima shall:

1. Distribute physician supplemental payments one (1) time each quarter; and

2. Provide a Remittance Advice Detail (RAD) to the **Health Network** for each quarterly payment that includes the following information:

a. **Provider** name;

b. **Provider** identification number;

c. **Member** name;

d. **Member** identification number;

e. Date of service;

f. Bill code; and

g. Amount paid.

H. A **Health Network** has the right to file a complaint disputing CalOptima's supplemental OB delivery care payment in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
C. CalOptima Policy FF.1010: Shared Risk Pool
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. Title 42, Code of Federal Regulations (CFR), §438.608(d)(2)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2010	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	01/01/2014	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2015	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2016	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	04/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2018	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2019	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal

IX. GLOSSARY

Term	Definition
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Care Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Overpayment	Any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima's Contract for Health Care Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. C. Authorize and Direct the Chief Executive Officer to Execute Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan (Kaiser)

Contact

Julie Bomgren, Director, Government Affairs, (714) 246-8400

Recommended Actions

1. Authorize and Direct the Chief Executive Officer (CEO) to execute a three-way agreement with the DHCS and Kaiser related to the transition of Healthy Families Program (HFP) children and Medi-Cal beneficiaries who are former Kaiser members or family-linked within the previous 12 months.
2. Authorize and Direct the CEO to execute an agreement with Kaiser related to transitioning certain defined categories of members to Kaiser as described in the two-way agreement.
3. Authorize and direct the CEO to enter into an amendment of the current Medi-Cal agreement with Kaiser consistent with these agreements.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In 1995, CalOptima entered into an agreement with Kaiser to provide health care services under CalOptima's Medi-Cal program. As a Health Network for Medi-Cal, Kaiser currently provides health care services, including pharmacy services to approximately 11,500 CalOptima Medi-Cal members. Along with CalOptima, Kaiser is a health plan in the HFP and serves approximately 13,500 HFP children in Orange County. With the elimination of HFP, and in accordance with the HFP transition implementation plan, children enrolled in Kaiser HFP will transition to CalOptima in Phase 2, anticipated to occur no sooner than April 1, 2013.

Discussion

In June 2012, the Legislature passed Assembly Bill (AB) 1494 which provides for the transition of all HFP subscribers to Medi-Cal.

In June 2012, Kaiser approached the State to consider the development of an agreement whereby Kaiser will retain its HFP members upon their transition into Medi-Cal through a direct contractual relationship with DHCS. As a direct contractual relationship in the existing managed care county delivery systems throughout California is not possible due to state and federal statutes, DHCS, Kaiser and the Medi-Cal managed care plans developed two agreements to address the HFP transition and future Medi-Cal enrollment.

DHCS/Kaiser/Plan Agreement

The first agreement is, by its own terms, a nonbinding agreement, between DHCS, Kaiser and the managed care plans. This template has already been signed by DHCS and Kaiser. It indicates that it sets forth a framework for a seamless transition of care for current Kaiser members in the HFP and Medi-Cal beneficiaries who were Kaiser members or family-linked within the previous twelve months.

The three-way agreement includes the following provisions:

1. DHCS, Kaiser and managed care plans will work to develop a contract template for the subcontract between plans and Kaiser.
2. A centralized oversight and compliance process to include a uniform policies and procedures audit program will be created to oversee Kaiser's obligations under the contract template (it may be necessary for two processes, one for Northern California and one for Southern California). The agreement indicates that this process will be conducted and funded by DHCS unless otherwise agreed to by the parties.
3. A process will be developed to improve the existing and future enrollment processes for Kaiser members including a validation process (of the applicant's eligibility to choose Kaiser).
4. In COHS counties including Orange County, the enrollment process for current/previous Kaiser members will mimic the existing process for all Medi-Cal members. The COHS plans such as CalOptima will assign to Kaiser new Medi-Cal members currently or previously enrolled with Kaiser in the previous twelve months or family-linked in the previous twelve months. This auto assignment to Kaiser is contingent upon COHS plans receiving required and accurate data from Kaiser and federal and state regulators. COHS members will be assigned to Kaiser only upon verification of previous coverage by Kaiser.
5. The agreement does not restrict the ability of Medi-Cal beneficiaries to choose a different provider than Kaiser during or after the beneficiary has been assigned to CalOptima.

Kaiser/Plan Agreement

The second agreement, between Kaiser and the managed care plan, is titled "Care Continuity Agreement" and defines the beneficiaries for whom the managed care plan will ensure transition to Kaiser as: 1) all members of CalOptima currently assigned to Kaiser; 2) individuals who are eligible for Medi-Cal on and after January 1, 2014 under Medi-Cal expansion and who enroll in CalOptima and are assigned to Kaiser; 3) HFP beneficiaries who are Kaiser members on the effective date of the transition; and 4) beneficiaries who are eligible for Medi-Cal or HFP after the effective date of the transition and who were Kaiser members or family-linked within the previous twelve months. This agreement has been signed by Kaiser but does not include aid codes on the attachments.

The two-way agreement includes the following provisions:

1. Kaiser will provide rate development template (RDT) data to managed care plans for inclusion in the plan RDT for the rate setting process.

2. Effective July 1, 2013, for aid codes not directly funded through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), an administrative withhold by the managed care plan will not exceed 2% of the net capitation Medi-Cal amount (the withhold may be based on the plan risk-adjusted equivalent of the net capitation amount). For aid codes directly funded through CHIPRA, there will be no administrative fee withhold.
3. Managed care plan contracts with Kaiser will be amended to include these provisions. However this Agreement indicates that it may be terminated only upon execution of an amendment to the parties, and that the terms of this Agreement will be re-evaluated in five years.
4. Kaiser may enter into a direct contract with DHCS if Kaiser is unable to reach a subcontracting agreement with Plan.

Upon approval by the Board of Directors, CalOptima modified its Medi-Cal auto assignment policy to accommodate the transition of HFP members and to the extent possible, preserve the provider/member and member/health network relationships. For children transitioning from other HFP health plans to Medi-Cal, CalOptima anticipates that DHCS will provide the Medi-Cal health plan a file that will include the incoming health plan code and name for transitioning HFP children. In order to ensure a seamless transition of care for Kaiser members, it will be necessary that CalOptima receive a timely, clean file for processing. Otherwise, CalOptima staff will follow our standard new member auto assignment process.

Fiscal Impact
With Kaiser's current membership, the 2% administrative withhold provision equates to approximately $250,000 annually which is one-half of the amount regularly included in DHCS capitation rates for administration. However, as an HMO, Kaiser will perform some of the functions that CalOptima would normally be responsible for, which will reduce CalOptima's cost accordingly.

Rationale for Recommendation
These template agreements were negotiated with DHCS, Kaiser and managed care plans and the provisions for transitioning HFP members are consistent with the requirements included in the recent amendment to CalOptima's Primary Agreement with DHCS related to the transition of HFP subscribers into Medi-Cal.

Concurrence
Michael H. Ewing, Chief Financial Officer
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *3/1/2013*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
26. Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term

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

Recommended Action
Ratify the amendment to the current Kaiser Foundation Health Plan, Inc. (Kaiser) Health Network Contract to extend the current term through the date of the next CalOptima Board meeting, November 5, 2020.

Background
Kaiser participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Kaiser's current Health Network Contract expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS-required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments.

CalOptima and Kaiser staff worked with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. To allow time for Kaiser and CalOptima to obtain all necessary information and final clarification from DHCS and complete discussions regarding the Amended and Restated Contract, the parties entered into an initial ninety (90) day extension of Kaiser's current contract through September 30, 2020. Due to the June 30, 2020 expiration date of the current Kaiser Health Network Contract, this extension was ratified by the Board on August 6, 2020.

Discussion
The parties continue to review certain provisions of the Amended and Restated Contract that memorialize operational requirements in light of Kaiser's unique model as well as the five (5) subsequent amendments that implement Prop 56, Health Homes Program requirements and other terms (Contract Amendments). Additionally, because Kaiser is the only CalOptima Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser staff are addressing terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract when the State implements its Medi-Cal Rx program effective January 1, 2021 including, revised rates and DHCS-mandated transition terms.

While CalOptima and Kaiser staff have attempted to complete all contract and amendment revisions by September 30, 2020, it will take another thirty (30) days to finalize these issues. Kaiser has requested an additional thirty (30) day extension of the current Kaiser Contract on the same terms and conditions to complete the discussions and finalize the Amended and Restated Contract and Contract Amendments. Because Staff intends to present the final Kaiser Amended and Restated Contract and Contract

Amendments to the Board for approval at the November 5, 2020 meeting, Staff requests that the Board ratify the extension of the current Kaiser Health Network Contract through that date.

Fiscal Impact

The recommended action to amend the current Kaiser Health Network Contract to extend the term through November 5, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

Amending the current Kaiser Health Network Contract to extend through November 5, 2020, the date of the Board's next meeting, under the same terms and conditions will allow the additional time needed to review and finalize Kaiser's FY 2020-21 Amended and Restated Health Network Contract.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated August 6, 2020; "Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract"

/s/ Richard Sanchez — *09/23/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

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

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

Recommended Actions
Ratify the amendment to the Kaiser Foundation Health Plan, Inc. (Kaiser) Health Network contract, extending the term through September 30, 2020.

Background/Discussion
Kaiser participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Each of CalOptima's contracts with its 12 twelve Medi-Cal Health Networks, including Kaiser, include a provision permitting an annual one-year extension of the contract subject to CalOptima Board of Directors' approval and signed contract amendments. Kaiser's current Health Network Contract ("Kaiser Contract") expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments. Kaiser has not, however, executed the Amended and Restated Contract. CalOptima and Kaiser have been working with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. The parties have also been reviewing certain contract provisions that memorialize operational requirements in light of Kaiser's unique staff model.

In order to allow time for Kaiser and CalOptima to obtain final clarification from DHCS and finalize discussions with Kaiser, the parties entered into a ninety (90) day extension of the Kaiser Contract through September 30, 2020, subject to Board approval. Additionally, because Kaiser is the only Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser also need to address contract terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract. The pharmacy benefit carve-out will be effective January 1, 2021 for all Managed Care Plans, including CalOptima.

Staff recommends ratification of the Kaiser Contract amendment to provide additional time to obtain DHCS's final guidance, and for the parties to reach agreement on the Amended and Restated Contract terms.

Fiscal Impact
The recommended action to ratify the amendment to the Kaiser Contract to extend the term through September 30, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima FY 2020-21 Operating Budget approved by the Board on June 4, 2020.

Back to Agenda Back to Item

Rationale for Recommendation

This extension will allow additional time to review and finalize Kaiser's FY 2020-21 Health Network contract.

.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action Dated June 4, 2020; "Authorize Extension and Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contracts with Kaiser Permanente

/s/ Richard Sanchez *07/29/2020*

Authorized Signature **Date**

A Public Agency

CalOptima

Better. Together.

Financial Summary

September 30, 2020

Board of Directors Meeting
November 5, 2020

Nancy Huang, Chief Financial Officer

Back to Agenda

FY 2020–21: Management Summary

- Change in Net Assets (Deficit) or Surplus
  - MTD: $6.5 million, favorable to budget $3.7 million or 132.8%
  - YTD: $1.4 million, favorable to budget $4.3 million or 148.1%
- Enrollment
  - MTD: 787,920 members, favorable to budget 527 or 0.1%
  - YTD: 2,340,406 member months, favorable to budget 3,565 or 0.2%
- Revenue
  - MTD: $423.7 million, favorable to budget $102.1 million or 31.8%
    - Driven by Medi-Cal line of business (LOB) $103.2 million of fiscal year (FY) 2019 hospital Directed Payments (DP) and $4.9 million of Whole Child Model (WCM) prior year revenue due to restated enrollment, offset by Proposition 56 risk corridor estimate
  - YTD: $1.0 billion, favorable to budget $72.1 million or 7.5% driven by Medi-Cal line of business:
    - Primarily driven by Medi-Cal LOB FY 2019 hospital DP, offset by bridge period Gross Medical Expense (GME) and Proposition 56 risk corridor estimates

Back to Agenda

CalOptima
A Public Agency

FY 2020–21: Management Summary (cont.)

- Medical Expenses
  - MTD: $405.6 million, unfavorable to budget $98.3 million or 32.0%
    - Driven by Medi-Cal LOB $103.2 million unfavorable variance due to hospital DP, offset by decrease in utilization due to COVID-19 pandemic
  - YTD: $996.6 million, unfavorable to budget $70.8 million or 7.6%
    - Primarily driven by Medi-Cal LOB FY 2019 hospital DP, offset by decrease in utilization due to COVID-19 pandemic
- Administrative Expenses
  - MTD: $11.4 million, favorable to budget $1.3 million or 10.0%
  - YTD: $33.4 million, favorable to budget $5.0 million or 13.1%
- Net Investment & Other Income
  - MTD: ($0.1) million, unfavorable to budget $1.4 million or 110.2%
  - YTD: $1.6 million, unfavorable to budget $2.1 million or 56.8%

Back to Agenda

CalOptima
A Public Agency

FY 2020–21: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 95.7% (94.4% excluding DP), Budget 95.6%
  - YTD: Actual 96.8% (96.4% excluding DP), Budget 96.7%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 2.7% (3.6% excluding DP), Budget 3.9%
  - YTD: Actual 3.2% (3.6% excluding DP), Budget 4.0%
- Balance Sheet Ratios
  - Current ratio: 1.3
  - Board-designated reserve funds level: 1.95
  - Net position: $1.0 billion, including required Tangible Net Equity (TNE) of $102.4 million

Back to Agenda

CalOptima
A Public Agency

Enrollment Summary: September 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
113,044	110,857	2,187	2.0%	SPD	338,554	332,449	6,105	1.8%
518	485	33	6.8%	BCCTP	1,538	1,467	71	4.8%
289,351	306,002	(16,651)	(5.4%)	TANF Child	869,380	905,027	(35,647)	(3.9%)
97,148	92,042	5,106	5.5%	TANF Adult	287,432	272,323	15,109	5.5%
4,891	3,509	1,382	39.4%	LTC	14,495	10,521	3,974	37.8%
253,445	246,699	6,746	2.7%	MCE	748,328	731,588	16,740	2.3%
13,020	11,932	1,088	9.1%	WCM	31,359	35,796	(4,437)	(12.4%)
771,417	**771,526**	**(109)**	**(0.0%)**	**Medi-Cal Total**	**2,291,086**	**2,289,171**	**1,915**	**0.1%**
14,529	**14,080**	**449**	**3.2%**	**OneCare Connect**	**43,535**	**42,321**	**1,214**	**2.9%**
1,594	**1,378**	**216**	**15.7%**	**OneCare**	**4,642**	**4,134**	**508**	**12.3%**
380	**409**	**(29)**	**(7.1%)**	**PACE**	**1,143**	**1,215**	**(72)**	**(5.9%)**
787,920	**787,393**	**527**	**0.1%**	**CalOptima Total**	**2,340,406**	**2,336,841**	**3,565**	**0.2%**

Back to Agenda

CalOptima
A Public Agency

Financial Highlights: September 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
787,920	787,393	527	0.1%	Member Months	2,340,406	2,336,841	3,565	0.2%
423,665,786	321,534,801	102,130,985	31.8%	Revenues	1,029,727,484	957,580,299	72,147,185	7.5%
405,600,875	307,305,145	(98,295,730)	(32.0%)	Medical Expenses	996,560,330	925,748,842	(70,811,488)	(7.6%)
11,398,770	12,670,898	1,272,128	10.0%	Administrative Expenses	33,405,555	38,453,777	5,048,222	13.1%
6,666,141	**1,558,758**	**5,107,383**	**327.7%**	**Operating Margin**	**(238,402)**	**(6,622,320)**	**6,383,918**	**96.4%**
(127,077)	1,250,000	(1,377,077)	(110.2%)	Non Operating Income (Loss)	1,621,158	3,750,000	(2,128,842)	(56.8%)
6,539,064	**2,808,758**	**3,730,306**	**132.8%**	**Change in Net Assets**	**1,382,757**	**(2,872,320)**	**4,255,077**	**148.1%**
95.7%	95.6%	(0.2%)		Medical Loss Ratio	96.8%	96.7%	(0.1%)	
2.7%	3.9%	1.3%		Administrative Loss Ratio	3.2%	4.0%	0.8%	
1.6%	0.5%	1.1%		Operating Margin Ratio	(0.0%)	(0.7%)	0.7%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
94.4%	95.6%	1.2%		*MLR (excluding Directed Payments)	96.4%	96.7%	0.3%	
3.6%	3.9%	0.4%		*ALR (excluding Directed Payments)	3.6%	4.0%	0.4%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

Back to Agenda

CalOptima
A Public Agency

Consolidated Performance Actual vs. Budget: September 2020 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
4.5	2.0	2.5	Medi-Cal	(1.6)	(4.5)	2.9
1.6	(0.7)	2.3	OCC	(0.4)	(2.9)	2.4
0.2	0.1	0.1	OneCare	0.3	0.2	0.2
0.4	0.2	0.2	PACE	1.5	0.6	0.9
6.7	**1.6**	**5.1**	**Operating**	**(0.2)**	**(6.6)**	**6.4**
(0.1)	1.3	(1.4)	Inv./Rental Inc, MCO tax	1.6	3.8	(2.1)
(0.1)	**1.3**	**(1.4)**	**Non-Operating**	**1.6**	**3.8**	**(2.1)**
6.5	**2.8**	**3.7**	**TOTAL**	**1.4**	**(2.9)**	**4.3**

Back to Agenda

CalOptima
A Public Agency

Consolidated Revenue & Expenses: September 2020 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	504,952	253,445	13,020	771,417	14,529	1,594	380	787,920
REVENUES								
Capitation Revenue	205,618,162	$ 153,725,881	$ 25,256,176	$ 384,600,219	$ 33,838,826	$ 2,031,136	$ 3,195,605	$ 423,665,786
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	205,618,162	153,725,881	25,256,176	384,600,219	33,838,826	2,031,136	3,195,605	423,665,786
MEDICAL EXPENSES								
Provider Capitation	35,355,856	42,904,125	10,024,110	88,284,091	15,718,385	568,898		104,571,374
Facilities	26,484,667	24,444,036	1,995,805	52,924,507	5,218,341	424,551	663,998	59,231,397
Professional Claims	19,705,256	9,088,823	991,707	29,785,786	1,045,331	83,580	574,305	31,489,002
Prescription Drugs	20,185,684	25,497,346	4,059,085	49,742,116	6,060,626	572,749	336,642	56,712,133
MLTSS	35,451,562	2,952,202	2,101,998	40,505,761	1,316,522	6,551	(9,962)	41,818,873
Medical Management	2,220,019	1,401,099	295,108	3,916,227	1,037,676	45,693	896,068	5,895,664
Quality Incentives	999,481	587,162	37,818	1,624,461	217,785		4,750	1,846,996
Reinsurance & Other	57,300,392	46,467,706	19,604	103,787,702	140,596		107,138	104,035,436
Total Medical Expenses	197,702,918	153,342,498	19,525,235	370,570,651	30,755,263	1,702,022	2,572,939	405,600,875
Medical Loss Ratio	96.2%	99.8%	77.3%	96.4%	90.9%	83.8%	80.5%	95.7%
GROSS MARGIN	**7,915,244**	**383,383**	**5,730,941**	**14,029,568**	**3,083,563**	**329,114**	**622,666**	**18,064,911**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,708,925	709,779	85,181	136,741	7,640,626
Professional fees				308,388	5,333	16,000	247	329,968
Purchased services				759,832	91,512	7,945	5,123	864,411
Printing & Postage				124,779	55,587	17,122	50,556	248,044
Depreciation & Amortization				290,036			2,018	292,054
Other expenses				1,582,517	36,262		3,317	1,622,095
Indirect cost allocation & Occupancy				(276,737)	629,387	47,628	1,294	401,571
Total Administrative Expenses				9,497,740	1,527,860	173,875	199,295	11,398,770
Admin Loss Ratio				2.5%	4.5%	8.6%	6.2%	2.7%
INCOME (LOSS) FROM OPERATIONS				4,531,829	1,555,703	155,238	423,371	6,666,141
INVESTMENT INCOME								326,968
TOTAL MCO TAX				(458,114)				(458,114)
TOTAL GRANT INCOME				4,050				4,050
OTHER INCOME				20				20
CHANGE IN NET ASSETS				**$ 4,077,784**	**$ 1,555,703**	**$ 155,238**	**$ 423,371**	**$ 6,539,064**
BUDGETED CHANGE IN NET ASSETS				2,005,887	(732,384)	66,797	218,458	2,808,758
VARIANCE TO BUDGET - FAV (UNFAV)				$ 2,071,897	$ 2,288,087	$ 88,441	$ 204,913	$ 3,730,306

Back to Agenda

CalOptima
A Public Agency

Consolidated Revenue & Expenses: September 2020 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,511,399	748,328	31,359	2,291,086	43,535	4,642	1,143	2,340,406
REVENUES								
Capitation Revenue	507,941,282	$ 358,323,813	$ 61,287,137	$ 927,552,232	$ 86,735,693	$ 5,894,250	$ 9,545,309	$ 1,029,727,484
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	507,941,282	358,323,813	61,287,137	927,552,232	86,735,693	5,894,250	9,545,309	1,029,727,484
MEDICAL EXPENSES								
Provider Capitation	106,771,293	127,614,354	31,978,120	266,363,767	37,868,048	1,605,202		305,837,018
Facilities	74,527,717	69,311,813	8,267,484	152,107,014	14,152,902	1,340,712	2,176,515	169,777,143
Professional Claims	58,440,916	27,409,072	3,358,510	89,208,497	2,933,800	237,750	1,686,202	94,066,249
Prescription Drugs	61,789,217	75,028,533	10,306,449	147,124,199	19,015,973	1,735,474	869,705	168,745,351
MLTSS	109,953,400	8,960,293	6,487,480	125,401,174	4,470,726	73,386	(9,873)	129,935,413
Medical Management	6,952,535	4,107,831	878,910	11,939,276	3,193,560	119,149	2,492,529	17,744,513
Quality Incentives	2,563,915	1,506,508	100,539	4,170,962	645,705		14,288	4,830,955
Reinsurance & Other	58,007,353	46,835,745	41,270	104,884,368	396,637		342,684	105,623,689
Total Medical Expenses	479,006,346	360,774,150	61,418,762	901,199,258	82,677,352	5,111,672	7,572,048	996,560,330
Medical Loss Ratio	94.3%	100.7%	100.2%	97.2%	95.3%	86.7%	79.3%	96.8%
GROSS MARGIN	**28,934,936**	**(2,450,336)**	**(131,626)**	**26,352,973**	**4,058,341**	**782,578**	**1,973,260**	**33,167,153**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				20,083,378	2,174,484	261,696	411,123	22,930,682
Professional fees				789,306	16,000	48,000	410	853,716
Purchased services				2,048,002	258,417	17,332	8,165	2,331,915
Printing & Postage				587,623	186,917	28,549	55,129	858,217
Depreciation & Amortization				876,556			6,125	882,681
Other expenses				4,281,277	114,834	205	8,838	4,405,154
Indirect cost allocation & Occupancy				(720,690)	1,736,371	117,998	9,513	1,143,191
Total Administrative Expenses				27,945,451	4,487,022	473,779	499,303	33,405,555
Admin Loss Ratio				3.0%	5.2%	8.0%	5.2%	3.2%
INCOME (LOSS) FROM OPERATIONS				(1,592,478)	(428,680)	308,799	1,473,958	(238,402)
INVESTMENT INCOME								3,343,146
TOTAL MCO TAX				(1,733,107)				(1,733,107)
TOTAL GRANT INCOME				10,913				10,913
OTHER INCOME				207				207
CHANGE IN NET ASSETS				**$ (3,314,465)**	**$ (428,680)**	**$ 308,799**	**$ 1,473,958**	**$ 1,382,757**
BUDGETED CHANGE IN NET ASSETS				(4,460,918)	(2,875,834)	156,121	558,311	(2,872,320)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 1,146,453	$ 2,447,154	$ 152,678	$ 915,647	$ 4,255,077

Back to Agenda

CalOptima
A Public Agency

Balance Sheet: As of September 2020

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$284,740,279	Accounts Payable	$78,560,784
Investments	891,165,559	Medical Claims liability	905,686,994
Capitation receivable	326,098,561	Accrued Payroll Liabilities	16,648,281
Receivables - Other	49,066,605	Deferred Revenue	21,883,519
Prepaid expenses	6,185,523	Deferred Lease Obligations	152,624
		Capitation and Withholds	151,785,687
Total Current Assets	**1,557,256,527**	**Total Current Liabilities**	**1,174,717,888**
Capital Assets			
Furniture & Equipment	39,890,502		
Building/Leasehold Improvements	10,852,654		
505 City Parkway West	51,620,226		
	102,363,381		
Less: accumulated depreciation	(54,836,309)		
Capital assets, net	47,527,072	Other (than pensions) post employment benefits liability	25,938,821
Other Assets		Net Pension Liabilities	27,321,866
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	57,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,227,978,574**
Cash and Cash Equivalents	3,479,829		
Long-term Investments	583,746,489	**Deferred Inflows**	
Total Board-designated Assets	587,226,318	Excess Earnings	506,547
		OPEB 75 Difference in Experience	804,000
		Change in Assumptions	3,728,725
Total Other Assets	644,725,231	OPEB Changes in Assumptions	1,638,000
		Net Position	
TOTAL ASSETS	**2,249,508,830**	TNE	102,433,561
		Funds in Excess of TNE	924,080,492
Deferred Outflows		**TOTAL NET POSITION**	1,026,514,054
Contributions	1,047,297		
Difference in Experience	4,280,308		
Excess Earning	-		
Changes in Assumptions	5,060,465		
OPEB 75 Changes in Assumptions	703,000		
Pension Contributions	570,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,261,169,900**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,261,169,900**

Back to Agenda

CalOptima
A Public Agency

Board Designated Reserve and TNE Analysis: As of September 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,665,965				
	Tier 1 - MetLife	159,458,405				
	Tier 1 - Wells Capital	159,798,287				
Board-designated Reserve		479,922,656	319,097,426	499,753,563	160,825,231	(19,830,907)
TNE Requirement	Tier 2 - MetLife	107,303,662	102,433,561	102,433,561	4,870,100	4,870,100
	Consolidated:	**587,226,318**	**421,530,987**	**602,187,124**	**165,695,331**	**(14,960,806)**
	Current reserve level	*1.95*	*1.40*	*2.00*		

Back to Agenda

CalOptima
A Public Agency

Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

Back to Agenda

CalOptima
A Public Agency



UNAUDITED FINANCIAL STATEMENTS

September 30, 2020

Back to Agenda

Table of Contents

Financial Highlights 3
Financial Dashboard 4
Statement of Revenues and Expenses – Consolidated Month to Date 5
Statement of Revenues and Expenses – Consolidated Year to Date 6
Statement of Revenues and Expenses – Consolidated LOB Month to Date 7
Statement of Revenues and Expenses – Consolidated LOB Year to Date 8
Highlights – Overall 9
Enrollment Summary 10
Enrollment Trended by Network Type 11
Highlights – Enrollment 12
Statement of Revenues and Expenses – Medi-Cal 13
Highlights – Medi-Cal 14
Statement of Revenues and Expenses – OneCare Connect 15
Highlights – OneCare Connect 16
Statement of Revenues and Expenses – OneCare 17
Statement of Revenues and Expenses – PACE 18
Statement of Revenues and Expenses – 505 City Parkway 19
Highlights – OneCare, PACE & 505 City Parkway 20
Balance Sheet 21
Board Designated Reserve & TNE Analysis 22
Statement of Cash Flow 23
Highlights – Balance Sheet & Statement of Cash Flow 24
Homeless Health Reserve Report 25
Budget Allocation Changes 26

Back to Agenda

September 30, 2020 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $6.5 million, $3.7 million favorable to budget
- Operating surplus is $6.7 million, with a deficit in non-operating income of $0.1 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $1.4 million, $4.3 million favorable to budget
- Operating deficit is ($0.2) million, with a surplus in non-operating income of $1.6 million

Change in Net Assets by Line of Business (LOB) ($ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
4.5	2.0	2.5	Medi-Cal	(1.6)	(4.5)	2.9
1.6	(0.7)	2.3	OCC	(0.4)	(2.9)	2.4
0.2	0.1	0.1	OneCare	0.3	0.2	0.2
0.4	0.2	0.2	PACE	1.5	0.6	0.9
6.7	**1.6**	**5.1**	**Operating**	**(0.2)**	**(6.6)**	**6.4**
(0.1)	1.3	(1.4)	Inv./Rental Inc, MCO tax	1.6	3.8	(2.1)
(0.1)	**1.3**	**(1.4)**	**Non-Operating**	**1.6**	**3.8**	**(2.1)**
6.5	**2.8**	**3.7**	**TOTAL**	**1.4**	**(2.9)**	**4.3**

CalOptima
Financial Dashboard
For the Three Months Ended September 30, 2020

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	771,417	771,526	(109)	(0.0%)
OneCare Connect	14,529	14,080	449	3.2%
OneCare	1,594	1,378	216	15.7%
PACE	380	409	(29)	(7.1%)
Total	787,920	787,393	527	0.1%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 4,078	$ 2,006	$ 2,072	103.3%
OneCare Connect	1,556	(732)	2,288	312.4%
OneCare	155	67	88	132.4%
PACE	423	218	205	93.8%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	327	1,250	(923)	(73.8%)
Total	$ 6,539	$ 2,809	$ 3,730	132.8%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96.4%	95.6%	(0.7)
OneCare Connect	90.9%	96.6%	5.7
OneCare	83.8%	87.9%	4.1

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,498	$ 10,759	$ 1,262	11.7%
OneCare Connect	1,528	1,606	78	4.9%
OneCare	174	137	(37)	(27.2%)
PACE	199	169	(31)	(18.1%)
Total	$ 11,399	$ 12,671	$ 1,272	10.0%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,067	1,161	94
OneCare Connect	187	210	23
OneCare	10	9	(1)
PACE	91	116	26
Total	1,354	1,496	142

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	723	665	58
OneCare Connect	78	67	11
OneCare	154	148	6
PACE	4	4	1
Total	959	883	76

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	2,291,086	2,289,171	1,915	0.1%
OneCare Connect	43,535	42,321	1,214	2.9%
OneCare	4,642	4,134	508	12.3%
PACE	1,143	1,215	(72)	(5.9%)
Total	2,340,406	2,336,841	3,565	0.2%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (3,314)	$ (4,461)	$ 1,146	25.7%
OneCare Connect	(429)	(2,876)	2,447	85.1%
OneCare	309	156	153	97.8%
PACE	1,474	558	916	164.0%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	3,343	3,750	(407)	(10.9%)
Total	$ 1,383	$ (2,873)	$ 4,256	148.1%

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.2%	96.7%	(0.4)
OneCare Connect	95.3%	97.4%	2.1
OneCare	86.7%	88.8%	2.0

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 27,945	$ 32,693	$ 4,747	14.5%
OneCare Connect	4,487	4,869	382	7.8%
OneCare	474	413	(61)	(14.6%)
PACE	499	479	(20)	(4.2%)
Total	$ 33,406	$ 38,454	$ 5,048	13.1%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	3,271	3,482	211
OneCare Connect	575	629	55
OneCare	31	28	(3)
PACE	269	349	80
Total	4,146	4,488	343

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	700	657	43
OneCare Connect	76	67	9
OneCare	152	148	4
PACE	4	3	1
Total	933	876	56

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended September 30, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	787,920		787,393		527	
REVENUE						
Medi-Cal	$ 384,600,219	$ 498.56	$ 290,665,728	$ 376.74	$ 93,934,491	$ 121.82
OneCare Connect	33,838,826	2,329.05	25,858,218	1,836.52	7,980,608	492.53
OneCare	2,031,136	1,274.24	1,686,604	1,223.95	344,532	50.29
PACE	3,195,605	8,409.49	3,324,251	8,127.75	(128,646)	281.74
Total Operating Revenue	423,665,786	537.70	321,534,801	408.35	102,130,985	129.35
MEDICAL EXPENSES						
Medi-Cal	370,570,651	480.38	277,900,422	360.20	(92,670,229)	(120.18)
OneCare Connect	30,755,263	2,116.82	24,984,620	1,774.48	(5,770,643)	(342.34)
OneCare	1,702,022	1,067.77	1,483,083	1,076.26	(218,939)	8.49
PACE	2,572,939	6,770.89	2,937,020	7,180.98	364,081	410.09
Total Medical Expenses	405,600,875	514.77	307,305,145	390.28	(98,295,730)	(124.49)
GROSS MARGIN	18,064,911	22.93	14,229,656	18.07	3,835,255	4.86
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,640,626	9.70	7,916,033	10.05	275,407	0.35
Professional fees	329,968	0.42	369,342	0.47	39,374	0.05
Purchased services	864,411	1.10	1,277,201	1.62	412,790	0.52
Printing & Postage	248,044	0.31	569,734	0.72	321,690	0.41
Depreciation & Amortization	292,054	0.37	460,570	0.58	168,516	0.21
Other expenses	1,622,095	2.06	1,693,040	2.15	70,945	0.09
Indirect cost allocation & Occupancy expense	401,571	0.51	384,978	0.49	(16,593)	(0.02)
Total Administrative Expenses	11,398,770	14.47	12,670,898	16.09	1,272,128	1.62
INCOME (LOSS) FROM OPERATIONS	6,666,141	8.46	1,558,758	1.98	5,107,383	6.48
INVESTMENT INCOME						
Interest income	1,129,930	1.43	1,250,000	1.59	(120,070)	(0.16)
Realized gain/(loss) on investments	656,499	0.83	-	-	656,499	0.83
Unrealized gain/(loss) on investments	(1,459,462)	(1.85)	-	-	(1,459,462)	(1.85)
Total Investment Income	326,968	0.41	1,250,000	1.59	(923,032)	(1.18)
TOTAL MCO TAX	(458,114)	(0.58)	-	-	(458,114)	(0.58)
TOTAL GRANT INCOME	4,050	0.01	-	-	4,050	0.01
OTHER INCOME	20	-	-	-	20	-
CHANGE IN NET ASSETS	**6,539,064**	**8.30**	**2,808,758**	**3.57**	**3,730,306**	**4.73**
MEDICAL LOSS RATIO	**95.7%**		**95.6%**		**(0.2%)**	
ADMINISTRATIVE LOSS RATIO	**2.7%**		**3.9%**		**1.3%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	2,340,406		2,336,841		3,565	
REVENUE						
Medi-Cal	$ 927,552,232	$ 404.85	$ 864,798,713	$ 377.78	$ 62,753,519	$ 27.07
OneCare Connect	86,735,693	1,992.32	77,835,247	1,839.16	8,900,446	153.16
OneCare	5,894,250	1,269.77	5,068,077	1,225.95	826,173	43.82
PACE	9,545,309	8,351.10	9,878,262	8,130.26	(332,953)	220.84
Total Operating Revenue	1,029,727,484	439.98	957,580,299	409.78	72,147,185	30.20
MEDICAL EXPENSES						
Medi-Cal	901,199,258	393.35	836,567,000	365.45	(64,632,258)	(27.90)
OneCare Connect	82,677,352	1,899.10	75,842,530	1,792.08	(6,834,822)	(107.02)
OneCare	5,111,672	1,101.18	4,498,687	1,088.22	(612,985)	(12.96)
PACE	7,572,048	6,624.71	8,840,625	7,276.23	1,268,577	651.52
Total Medical Expenses	996,560,330	425.81	925,748,842	396.15	(70,811,488)	(29.66)
GROSS MARGIN	33,167,153	14.17	31,831,457	13.63	1,335,696	0.54
ADMINISTRATIVE EXPENSES						
Salaries and benefits	22,930,682	9.80	24,183,758	10.35	1,253,076	0.55
Professional fees	853,716	0.36	1,108,026	0.47	254,310	0.11
Purchased services	2,331,915	1.00	3,831,604	1.64	1,499,689	0.64
Printing & Postage	858,217	0.37	1,709,202	0.73	850,985	0.36
Depreciation & Amortization	882,681	0.38	1,381,710	0.59	499,029	0.21
Other expenses	4,405,154	1.88	5,082,726	2.18	677,572	0.30
Indirect cost allocation & Occupancy expense	1,143,191	0.49	1,156,751	0.50	13,560	0.01
Total Administrative Expenses	33,405,555	14.27	38,453,777	16.46	5,048,222	2.19
INCOME (LOSS) FROM OPERATIONS	(238,402)	(0.10)	(6,622,320)	(2.83)	6,383,918	2.73
INVESTMENT INCOME						
Interest income	3,676,990	1.57	3,750,000	1.60	(73,010)	(0.03)
Realized gain/(loss) on investments	2,318,301	0.99	-	-	2,318,301	0.99
Unrealized gain/(loss) on investments	(2,652,145)	(1.13)	-	-	(2,652,145)	(1.13)
Total Investment Income	3,343,146	1.43	3,750,000	1.60	(406,854)	(0.17)
TOTAL MCO TAX	(1,733,107)	(0.74)	-	-	(1,733,107)	(0.74)
TOTAL GRANT INCOME	10,913	-	-	-	10,913	-
OTHER INCOME	207	-	-	-	207	-
CHANGE IN NET ASSETS	**1,382,757**	**0.59**	**(2,872,320)**	**(1.23)**	**4,255,077**	**1.82**
MEDICAL LOSS RATIO	**96.8%**		**96.7%**		**(0.1%)**	
ADMINISTRATIVE LOSS RATIO	**3.2%**		**4.0%**		**0.8%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended September 30, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	504,952	253,445	13,020	771,417	14,529	1,594	380	787,920
REVENUES								
Capitation Revenue	205,618,162	$ 153,725,881	$ 25,256,176	$ 384,600,219	$ 33,838,826	$ 2,031,136	$ 3,195,605	$ 423,665,786
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	205,618,162	153,725,881	25,256,176	384,600,219	33,838,826	2,031,136	3,195,605	423,665,786
MEDICAL EXPENSES								
Provider Capitation	35,355,856	42,904,125	10,024,110	88,284,091	15,718,385	568,898		104,571,374
Facilities	26,484,667	24,444,036	1,995,805	52,924,507	5,218,341	424,551	663,998	59,231,397
Professional Claims	19,705,256	9,088,823	991,707	29,785,786	1,045,331	83,580	574,305	31,489,002
Prescription Drugs	20,185,684	25,497,346	4,059,085	49,742,116	6,060,626	572,749	336,642	56,712,133
MLTSS	35,451,562	2,952,202	2,101,998	40,505,761	1,316,522	6,551	(9,962)	41,818,873
Medical Management	2,220,019	1,401,099	295,108	3,916,227	1,037,676	45,693	896,068	5,895,664
Quality Incentives	999,481	587,162	37,818	1,624,461	217,785		4,750	1,846,996
Reinsurance & Other	57,300,392	46,467,706	19,604	103,787,702	140,596		107,138	104,035,436
Total Medical Expenses	197,702,918	153,342,498	19,525,235	370,570,651	30,755,263	1,702,022	2,572,939	405,600,875
Medical Loss Ratio	96.2%	99.8%	77.3%	96.4%	90.9%	83.8%	80.5%	95.7%
GROSS MARGIN	**7,915,244**	**383,383**	**5,730,941**	**14,029,568**	**3,083,563**	**329,114**	**622,666**	**18,064,911**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,708,925	709,779	85,181	136,741	7,640,626
Professional fees				308,388	5,333	16,000	247	329,968
Purchased services				759,832	91,512	7,945	5,123	864,411
Printing & Postage				124,779	55,587	17,122	50,556	248,044
Depreciation & Amortization				290,036			2,018	292,054
Other expenses				1,582,517	36,262		3,317	1,622,095
Indirect cost allocation & Occupancy				(276,737)	629,387	47,628	1,294	401,571
Total Administrative Expenses				9,497,740	1,527,860	173,875	199,295	11,398,770
Admin Loss Ratio				2.5%	4.5%	8.6%	6.2%	2.7%
INCOME (LOSS) FROM OPERATIONS				4,531,829	1,555,703	155,238	423,371	6,666,141
INVESTMENT INCOME								326,968
TOTAL MCO TAX				(458,114)				(458,114)
TOTAL GRANT INCOME				4,050				4,050
OTHER INCOME				20				20
CHANGE IN NET ASSETS				**$ 4,077,784**	**$ 1,555,703**	**$ 155,238**	**$ 423,371**	**$ 6,539,064**
BUDGETED CHANGE IN NET ASSETS				2,005,887	(732,384)	66,797	218,458	2,808,758
VARIANCE TO BUDGET - FAV (UNFAV)				$ 2,071,897	$ 2,288,087	$ 88,441	$ 204,913	$ 3,730,306

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Three Months Ended September 30, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,511,399	748,328	31,359	2,291,086	43,535	4,642	1,143	2,340,406
REVENUES								
Capitation Revenue	507,941,282	$ 358,323,813	$ 61,287,137	$ 927,552,232	$ 86,735,693	$ 5,894,250	$ 9,545,309	$ 1,029,727,484
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	507,941,282	358,323,813	61,287,137	927,552,232	86,735,693	5,894,250	9,545,309	1,029,727,484
MEDICAL EXPENSES								
Provider Capitation	106,771,293	127,614,354	31,978,120	266,363,767	37,868,048	1,605,202		305,837,018
Facilities	74,527,717	69,311,813	8,267,484	152,107,014	14,152,902	1,340,712	2,176,515	169,777,143
Professional Claims	58,440,916	27,409,072	3,358,510	89,208,497	2,933,800	237,750	1,686,202	94,066,249
Prescription Drugs	61,789,217	75,028,533	10,306,449	147,124,199	19,015,973	1,735,474	869,705	168,745,351
MLTSS	109,953,400	8,960,293	6,487,480	125,401,174	4,470,726	73,386	(9,873)	129,935,413
Medical Management	6,952,535	4,107,831	878,910	11,939,276	3,193,560	119,149	2,492,529	17,744,513
Quality Incentives	2,563,915	1,506,508	100,539	4,170,962	645,705		14,288	4,830,955
Reinsurance & Other	58,007,353	46,835,745	41,270	104,884,368	396,637		342,684	105,623,689
Total Medical Expenses	479,006,346	360,774,150	61,418,762	901,199,258	82,677,352	5,111,672	7,572,048	996,560,330
Medical Loss Ratio	94.3%	100.7%	100.2%	97.2%	95.3%	86.7%	79.3%	96.8%
GROSS MARGIN	**28,934,936**	**(2,450,336)**	**(131,626)**	**26,352,973**	**4,058,341**	**782,578**	**1,973,260**	**33,167,153**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				20,083,378	2,174,484	261,696	411,123	22,930,682
Professional fees				789,306	16,000	48,000	410	853,716
Purchased services				2,048,002	258,417	17,332	8,165	2,331,915
Printing & Postage				587,623	186,917	28,549	55,129	858,217
Depreciation & Amortization				876,556			6,125	882,681
Other expenses				4,281,277	114,834	205	8,838	4,405,154
Indirect cost allocation & Occupancy				(720,690)	1,736,371	117,998	9,513	1,143,191
Total Administrative Expenses				27,945,451	4,487,022	473,779	499,303	33,405,555
Admin Loss Ratio				3.0%	5.2%	8.0%	5.2%	3.2%
INCOME (LOSS) FROM OPERATIONS				(1,592,478)	(428,680)	308,799	1,473,958	(238,402)
INVESTMENT INCOME								3,343,146
TOTAL MCO TAX				(1,733,107)				(1,733,107)
TOTAL GRANT INCOME				10,913				10,913
OTHER INCOME				207				207
CHANGE IN NET ASSETS				**$ (3,314,465)**	**$ (428,680)**	**$ 308,799**	**$ 1,473,958**	**$ 1,382,757**
BUDGETED CHANGE IN NET ASSETS				(4,460,918)	(2,875,834)	156,121	558,311	(2,872,320)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 1,146,453	$ 2,447,154	$ 152,678	$ 915,647	$ 4,255,077

CalOptima - Consolidated
Financial Highlights
For the Three Months Ended September 30, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
787,920	787,393	527	0.1%	Member Months	2,340,406	2,336,841	3,565	0.2%
423,665,786	321,534,801	102,130,985	31.8%	Revenues	1,029,727,484	957,580,299	72,147,185	7.5%
405,600,875	307,305,145	(98,295,730)	(32.0%)	Medical Expenses	996,560,330	925,748,842	(70,811,488)	(7.6%)
11,398,770	12,670,898	1,272,128	10.0%	Administrative Expenses	33,405,555	38,453,777	5,048,222	13.1%
6,666,141	**1,558,758**	**5,107,383**	**327.7%**	**Operating Margin**	**(238,402)**	**(6,622,320)**	**6,383,918**	**96.4%**
(127,077)	1,250,000	(1,377,077)	(110.2%)	Non Operating Income (Loss)	1,621,158	3,750,000	(2,128,842)	(56.8%)
6,539,064	**2,808,758**	**3,730,306**	**132.8%**	**Change in Net Assets**	**1,382,757**	**(2,872,320)**	**4,255,077**	**148.1%**
95.7%	95.6%	(0.2%)		Medical Loss Ratio	96.8%	96.7%	(0.1%)	
2.7%	3.9%	1.3%		Administrative Loss Ratio	3.2%	4.0%	0.8%	
1.6%	0.5%	1.1%		Operating Margin Ratio	(0.0%)	(0.7%)	0.7%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
94.4%	95.6%	1.2%		*MLR (excluding Directed Payments)	96.4%	96.7%	0.3%	
3.6%	3.9%	0.4%		*ALR (excluding Directed Payments)	3.6%	4.0%	0.4%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

CalOptima - Consolidated
Enrollment Summary
For the Three Months Ended September 30, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
113,044	110,857	2,187	2.0%	SPD	338,554	332,449	6,105	1.8%
518	485	33	6.8%	BCCTP	1,538	1,467	71	4.8%
289,351	306,002	(16,651)	(5.4%)	TANF Child	869,380	905,027	(35,647)	(3.9%)
97,148	92,042	5,106	5.5%	TANF Adult	287,432	272,323	15,109	5.5%
4,891	3,509	1,382	39.4%	LTC	14,495	10,521	3,974	37.8%
253,445	246,699	6,746	2.7%	MCE	748,328	731,588	16,740	2.3%
13,020	11,932	1,088	9.1%	WCM	31,359	35,796	(4,437)	(12.4%)
771,417	**771,526**	**(109)**	**(0.0%)**	**Medi-Cal Total**	**2,291,086**	**2,289,171**	**1,915**	**0.1%**
14,529	**14,080**	**449**	**3.2%**	**OneCare Connect**	**43,535**	**42,321**	**1,214**	**2.9%**
1,594	**1,378**	**216**	**15.7%**	**OneCare**	**4,642**	**4,134**	**508**	**12.3%**
380	**409**	**(29)**	**(7.1%)**	**PACE**	**1,143**	**1,215**	**(72)**	**(5.9%)**
787,920	**787,393**	**527**	**0.1%**	**CalOptima Total**	**2,340,406**	**2,336,841**	**3,565**	**0.2%**
				Enrollment (by Network)				
174,042	172,152	1,890	1.1%	HMO	517,859	511,080	6,779	1.3%
215,806	222,556	(6,750)	(3.0%)	PHC	646,784	659,794	(13,010)	(2.0%)
181,767	188,748	(6,981)	(3.7%)	Shared Risk Group	547,825	557,613	(9,788)	(1.8%)
199,802	188,070	11,732	6.2%	Fee for Service	578,618	560,684	17,934	3.2%
771,417	**771,526**	**(109)**	**(0.0%)**	**Medi-Cal Total**	**2,291,086**	**2,289,171**	**1,915**	**0.1%**
14,529	**14,080**	**449**	**3.2%**	**OneCare Connect**	**43,535**	**42,321**	**1,214**	**2.9%**
1,594	**1,378**	**216**	**15.7%**	**OneCare**	**4,642**	**4,134**	**508**	**12.3%**
380	**409**	**(29)**	**(7.1%)**	**PACE**	**1,143**	**1,215**	**(72)**	**(5.9%)**
787,920	**787,393**	**527**	**0.1%**	**CalOptima Total**	**2,340,406**	**2,336,841**	**3,565**	**0.2%**

CalOptima
Enrollment Trend by Network
Fiscal Year 2021

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	YTD Actual	YTD Budget	Variance
HMOs															
SPD	10,536	10,583	10,588										31,707	31,067	640
BCCTP	1	1	1										3	3	0
TANF Child	54,644	55,088	55,115										164,847	170,785	(5,938)
TANF Adult	29,033	29,687	30,001										88,721	85,980	2,741
LTC	(1)	402	197										598	6	592
MCE	74,441	75,955	76,054										226,450	217,104	9,346
WCM	1,721	1,726	2,086										5,533	6,135	(602)
Total	**170,375**	**173,442**	**174,042**										**517,859**	**511,080**	**6,779**
PHCs															
SPD	7,145	7,205	6,855										21,205	21,068	137
BCCTP													-		0
TANF Child	149,810	151,008	148,874										449,692	467,537	(17,845)
TANF Adult	11,688	12,097	12,071										35,856	33,564	2,292
LTC		158	81										239	3	236
MCE	39,815	40,711	39,935										120,461	116,073	4,388
WCM	5,625	5,716	7,990										19,331	21,549	(2,218)
Total	**214,083**	**216,895**	**215,806**										**646,784**	**659,794**	**(13,010)**
Shared Risk Groups															
SPD	10,264	10,312	10,068										30,644	30,520	124
BCCTP													-		0
TANF Child	58,289	58,687	57,269										174,245	188,022	(13,777)
TANF Adult	28,914	29,648	29,235										87,797	86,264	1,533
LTC	1	365	178										544	6	538
MCE	82,747	84,907	83,063										250,717	247,723	2,994
WCM	924	1,000	1,954										3,878	5,078	(1,200)
Total	**181,139**	**184,919**	**181,767**										**547,825**	**557,613**	**(9,788)**
Fee for Service (Dual)															
SPD	74,615	75,198	75,269										225,082	220,276	4,806
BCCTP	12	17	18										47	51	(4)
TANF Child	1	1	1										3	6	(3)
TANF Adult	909	1,266	994										3,169	2,894	275
LTC	3,079	4,461	3,855										11,395	9,477	1,918
MCE	1,658	1,859	1,948										5,465	4,137	1,328
WCM	13	17	16										46	39	7
Total	**80,287**	**82,819**	**82,101**										**245,207**	**236,880**	**8,327**
Fee for Service (Non-Dual - Total)															
SPD	9,830	9,822	10,264										29,916	29,518	398
BCCTP	497	492	499										1,488	1,413	75
TANF Child	25,494	27,007	28,092										80,593	78,677	1,916
TANF Adult	23,028	24,014	24,847										71,889	63,621	8,268
LTC	351	788	580										1,719	1,029	690
MCE	45,498	47,292	52,445										145,235	146,551	(1,316)
WCM	791	806	974										2,571	2,995	(424)
Total	**105,489**	**110,221**	**117,701**										**333,411**	**323,804**	**9,607**
SPD	112,390	113,120	113,044										338,554	332,449	6,105
BCCTP	510	510	518										1,538	1,467	71
TANF Child	288,238	291,791	289,351										869,380	905,027	(35,647)
TANF Adult	93,572	96,712	97,148										287,432	272,323	15,109
LTC	3,430	6,174	4,891										14,495	10,521	3,974
MCE	244,159	250,724	253,445										748,328	731,588	16,740
WCM	9,074	9,265	13,020										31,359	35,796	(4,437)
Total Medi-Cal MM	**751,373**	**768,296**	**771,417**										**2,291,086**	**2,289,171**	**1,915**
OneCare Connect	**14,465**	**14,541**	**14,529**										**43,535**	**42,321**	**1,214**
OneCare	**1,525**	**1,523**	**1,594**										**4,642**	**4,134**	**508**
PACE	**382**	**381**	**380**										**1,143**	**1,215**	**(72)**
Grand Total	**767,745**	**784,741**	**787,920**										**2,340,406**	**2,336,841**	**3,565**

ENROLLMENT:

Overall, September enrollment was 787,920

- Favorable to budget 527 or 0.1%
- Increased 3,179 or 0.4% from prior month (PM) (August 2020)
- Increased 59,846 or 8.2% from prior year (PY) (September 2019)

Medi-Cal enrollment was 771,417

- Unfavorable to budget 109 or 0.0%
  - Temporary Assistance for Needy Families (TANF) unfavorable 11,545
  - Medi-Cal Expansion (MCE) favorable 6,746
  - Seniors and Persons with Disabilities (SPD) favorable 2,187
  - Long-Term Care (LTC) favorable 1,382
  - Whole Child Model (WCM) favorable 1,088 due to retroactive enrollment of 2,544
  - Breast and Cervical Cancer Treatment Program (BCCTP) favorable 33
- Increased 3,121 from PM

OneCare Connect enrollment was 14,529

- Favorable to budget 449 or 3.2%
- Decreased 12 from PM

OneCare enrollment was 1,594

- Favorable to budget 216 or 15.7%
- Increased 71 from PM

PACE enrollment was 380

- Unfavorable to budget 29 or 7.1%
- Decreased 1 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
771,417	**771,526**	**(109)**	**(0.0%)**	**Member Months**	**2,291,086**	**2,289,171**	**1,915**	**0.1%**
				Revenues				
384,600,219	290,665,728	93,934,491	32.3%	Capitation Revenue	927,552,232	864,798,713	62,753,519	7.3%
-	-	-	0.0%	Other Income	-	-	-	0.0%
384,600,219	**290,665,728**	**93,934,491**	**32.3%**	**Total Operating Revenue**	**927,552,232**	**864,798,713**	**62,753,519**	**7.3%**
				Medical Expenses				
89,908,552	98,188,911	8,280,359	8.4%	Provider Capitation	270,534,730	291,261,086	20,726,356	7.1%
52,924,507	56,884,677	3,960,170	7.0%	Facilities Claims	152,107,014	172,122,810	20,015,796	11.6%
29,785,786	32,192,550	2,406,764	7.5%	Professional Claims	89,208,497	97,554,419	8,345,922	8.6%
49,742,116	45,696,304	(4,045,812)	(8.9%)	Prescription Drugs	147,124,199	138,569,063	(8,555,136)	(6.2%)
40,505,761	39,445,674	(1,060,087)	(2.7%)	MLTSS	125,401,174	120,637,381	(4,763,793)	(3.9%)
3,916,227	4,888,298	972,071	19.9%	Medical Management	11,939,276	14,610,221	2,670,945	18.3%
103,787,702	604,008	(103,183,694)	(17083.2%)	Reinsurance & Other	104,884,368	1,812,020	(103,072,348)	(5688.3%)
370,570,651	**277,900,422**	**(92,670,229)**	**(33.3%)**	**Total Medical Expenses**	**901,199,258**	**836,567,000**	**(64,632,258)**	**(7.7%)**
14,029,568	**12,765,306**	**1,264,262**	**9.9%**	**Gross Margin**	**26,352,973**	**28,231,713**	**(1,878,740)**	**(6.7%)**
				Administrative Expenses				
6,708,925	6,933,169	224,244	3.2%	Salaries, Wages & Employee Benefits	20,083,378	21,209,436	1,126,058	5.3%
308,388	313,093	4,705	1.5%	Professional Fees	789,306	939,279	149,973	16.0%
759,832	1,146,263	386,431	33.7%	Purchased Services	2,048,002	3,438,790	1,390,788	40.4%
124,779	443,433	318,654	71.9%	Printing and Postage	587,623	1,330,299	742,676	55.8%
290,036	458,500	168,464	36.7%	Depreciation & Amortization	876,556	1,375,500	498,944	36.3%
1,582,517	1,673,105	90,588	5.4%	Other Operating Expenses	4,281,277	5,021,867	740,590	14.7%
(276,737)	(208,144)	68,593	33.0%	Indirect Cost Allocation, Occupancy Expense	(720,690)	(622,540)	98,150	15.8%
9,497,740	**10,759,419**	**1,261,679**	**11.7%**	**Total Administrative Expenses**	**27,945,451**	**32,692,631**	**4,747,180**	**14.5%**
				Operating Tax				
12,010,636	14,940,538	(2,929,902)	(19.6%)	Tax Revenue	35,673,143	44,337,079	(8,663,936)	(19.5%)
12,468,750	14,940,538	2,471,788	16.5%	Premium Tax Expense	37,406,250	44,337,079	6,930,829	15.6%
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
(458,114)	-	(458,114)	**0.0%**	**Total Net Operating Tax**	(1,733,107)	-	(1,733,107)	**0.0%**
				Grant Income				
35,409	-	35,409	0.0%	Grant Revenue	86,490	-	86,490	0.0%
22,950	-	(22,950)	0.0%	Grant expense - Service Partner	61,838	-	(61,838)	0.0%
8,409	-	(8,409)	0.0%	Grant expense - Administrative	13,740	-	(13,740)	0.0%
4,050	-	4,050	**0.0%**	**Total Grant Income**	10,913	-	10,913	**0.0%**
20	**-**	**20**	**0.0%**	**Other income**	**207**	**-**	**207**	**0.0%**
4,077,784	**2,005,887**	**2,071,897**	**103.3%**	**Change in Net Assets**	**(3,314,465)**	**(4,460,918)**	**1,146,453**	**25.7%**
96.4%	***95.6%***	***(0.7%)***	***(0.8%)***	***Medical Loss Ratio***	***97.2%***	***96.7%***	***(0.4%)***	***(0.4%)***
2.5%	***3.7%***	***1.2%***	***33.3%***	***Admin Loss Ratio***	***3.0%***	***3.8%***	***0.8%***	***20.3%***

MEDI-CAL INCOME STATEMENT – SEPTEMBER MONTH:

REVENUES of $384.6 million are favorable to budget $93.9 million driven by:

- Unfavorable volume related variance of $41,065
- Favorable price related variance of $94.0 million
  - $103.2 million of fiscal year (FY) 2019 hospital Directed Payments (DP)
  - $13.8 million for Coordinated Care Initiative (CCI) revenue
  - $4.9 million of WCM revenue due to retroactive enrollment
  - Offset by $19.1 million of Proposition 56 risk corridor

MEDICAL EXPENSES of $370.6 million are unfavorable to budget $92.7 million driven by:

- Favorable volume related variance of $39,261
- Unfavorable price related variance of $92.7 million
  - Reinsurance & Other expense unfavorable variance of $103.2 million due to FY 2019 DP
  - Prescription Drugs expense unfavorable variance of $4.1 million
  - Managed Long Term Services and Supports (MLTSS) expense unfavorable variance of $1.1 million
  - Offset by Provider Capitation expense favorable variance of $8.3 million due to decreased utilization during COVID-19 pandemic
  - Facilities Claims expense favorable variance of $4.0 million due to decreased utilization during COVID-19 pandemic
  - Professional Claims expense favorable variance of $2.4 million due to decreased utilization during COVID-19 pandemic

ADMINISTRATIVE EXPENSES of $9.5 million are favorable to budget $1.3 million driven by:

- Salaries & Benefit expense favorable to budget $0.2 million
- Other Non-Salary expense favorable to budget $1.0 million

CHANGE IN NET ASSETS is $4.1 million for the month, favorable to budget $2.1 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Three Months Ending September 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,529	**14,080**	**449**	**3.2%**	**Member Months**	**43,535**	**42,321**	**1,214**	**2.9%**
				Revenues				
3,003,230	2,718,375	284,855	10.5%	Medi-Cal Capitation Revenue	9,832,322	8,170,775	1,661,547	20.3%
24,987,481	17,918,703	7,068,778	39.4%	Medicare Capitation Revenue Part C	60,457,027	53,968,738	6,488,289	12.0%
5,848,115	5,221,140	626,975	12.0%	Medicare Capitation Revenue Part D	16,446,344	15,695,734	750,610	4.8%
-	-	-	0.0%	Other Income	-	-	-	0.0%
33,838,826	**25,858,218**	**7,980,608**	**30.9%**	**Total Operating Revenue**	**86,735,693**	**77,835,247**	**8,900,446**	**11.4%**
				Medical Expenses				
15,936,170	11,425,929	(4,510,241)	(39.5%)	Provider Capitation	38,513,753	34,448,634	(4,065,119)	(11.8%)
5,218,341	3,966,436	(1,251,905)	(31.6%)	Facilities Claims	14,152,902	12,036,485	(2,116,417)	(17.6%)
1,045,331	918,369	(126,962)	(13.8%)	Ancillary	2,933,800	2,803,446	(130,354)	(4.6%)
1,316,522	1,513,580	197,058	13.0%	MLTSS	4,470,726	4,657,678	186,952	4.0%
6,060,626	5,758,175	(302,451)	(5.3%)	Prescription Drugs	19,015,973	17,617,208	(1,398,765)	(7.9%)
1,037,676	1,190,500	152,824	12.8%	Medical Management	3,193,560	3,635,020	441,460	12.1%
140,596	211,631	71,035	33.6%	Other Medical Expenses	396,637	644,059	247,422	38.4%
30,755,263	**24,984,620**	**(5,770,643)**	**(23.1%)**	**Total Medical Expenses**	**82,677,352**	**75,842,530**	**(6,834,822)**	**(9.0%)**
3,083,563	**873,598**	**2,209,965**	**253.0%**	**Gross Margin**	**4,058,341**	**1,992,717**	**2,065,624**	**103.7%**
				Administrative Expenses				
709,779	786,617	76,838	9.8%	Salaries, Wages & Employee Benefits	2,174,484	2,409,462	234,978	9.8%
5,333	40,083	34,750	86.7%	Professional Fees	16,000	120,249	104,249	86.7%
91,512	103,412	11,900	11.5%	Purchased Services	258,417	310,236	51,819	16.7%
55,587	106,517	50,930	47.8%	Printing and Postage	186,917	319,551	132,634	41.5%
36,262	15,861	(20,401)	(128.6%)	Other Operating Expenses	114,834	48,577	(66,257)	(136.4%)
629,387	553,492	(75,895)	(13.7%)	Indirect Cost Allocation	1,736,371	1,660,476	(75,895)	(4.6%)
1,527,860	**1,605,982**	**78,122**	**4.9%**	**Total Administrative Expenses**	**4,487,022**	**4,868,551**	**381,529**	**7.8%**
1,555,703	**(732,384)**	**2,288,087**	**312.4%**	**Change in Net Assets**	**(428,680)**	**(2,875,834)**	**2,447,154**	**85.1%**
90.9%	***96.6%***	***5.7%***	***5.9%***	***Medical Loss Ratio***	***95.3%***	***97.4%***	***2.1%***	***2.2%***
4.5%	***6.2%***	***1.7%***	***27.3%***	***Admin Loss Ratio***	***5.2%***	***6.3%***	***1.1%***	***17.3%***

ONECARE CONNECT INCOME STATEMENT– SEPTEMBER MONTH:

REVENUES of $33.8 million are favorable to budget $8.0 million driven by:

- Favorable volume related variance of $0.8 million
- Favorable price related variance of $7.2 million due to calendar year (CY) 2018 Quality Withhold (QW) payment received from the Center for Medicare & Medicaid Services (CMS)

MEDICAL EXPENSES of $30.8 million are unfavorable to budget $5.8 million driven by:

- Unfavorable volume related variance of $0.8 million
- Unfavorable price related variance of $5.0 million
  - Provider Capitation expense unfavorable variance of $4.1 million due to CY 2018 QW payable to the Health Networks (HN)
  - Facilities Claims expense unfavorable variance of $1.1 million

ADMINISTRATIVE EXPENSES of $1.5 million are favorable to budget $0.1 million

CHANGE IN NET ASSETS is $1.6 million, favorable to budget $2.3 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,594	**1,378**	**216**	**15.7%**	**Member Months**	**4,642**	**4,134**	**508**	**12.3%**
				Revenues				
1,404,969	1,149,468	255,501	22.2%	Medicare Part C revenue	4,042,025	3,456,519	585,506	16.9%
626,167	537,136	89,031	16.6%	Medicare Part D revenue	1,852,225	1,611,558	240,667	14.9%
2,031,136	**1,686,604**	**344,532**	**20.4%**	**Total Operating Revenue**	**5,894,250**	**5,068,077**	**826,173**	**16.3%**
				Medical Expenses				
568,898	445,091	(123,807)	(27.8%)	Provider Capitation	1,605,202	1,338,405	(266,797)	(19.9%)
424,551	451,025	26,474	5.9%	Inpatient	1,340,712	1,367,384	26,672	2.0%
83,580	42,364	(41,216)	(97.3%)	Ancillary	237,750	128,611	(109,139)	(84.9%)
6,551	25,059	18,508	73.9%	Skilled Nursing Facilities	73,386	76,849	3,463	4.5%
572,749	476,102	(96,647)	(20.3%)	Prescription Drugs	1,735,474	1,455,241	(280,233)	(19.3%)
45,693	43,442	(2,251)	(5.2%)	Medical Management	119,149	132,197	13,048	9.9%
1,702,022	**1,483,083**	**(218,939)**	**(14.8%)**	**Total Medical Expenses**	**5,111,672**	**4,498,687**	**(612,985)**	**(13.6%)**
329,114	**203,521**	**125,593**	**61.7%**	**Gross Margin**	**782,578**	**569,390**	**213,188**	**37.4%**
				Administrative Expenses				
85,181	67,168	(18,013)	(26.8%)	Salaries, wages & employee benefits	261,696	204,601	(57,095)	(27.9%)
16,000	16,000	-	0.0%	Professional fees	48,000	48,000	-	0.0%
7,945	9,750	1,805	18.5%	Purchased services	17,332	29,250	11,918	40.7%
17,122	8,084	(9,038)	(111.8%)	Printing and postage	28,549	24,252	(4,297)	(17.7%)
-	537	537	100.0%	Other operating expenses	205	1,611	1,406	87.3%
47,628	35,185	(12,443)	(35.4%)	Indirect cost allocation, occupancy expens	117,998	105,555	(12,443)	(11.8%)
173,875	**136,724**	**(37,151)**	**(27.2%)**	**Total Administrative Expenses**	**473,779**	**413,269**	**(60,510)**	**(14.6%)**
155,238	**66,797**	**88,441**	**132.4%**	**Change in Net Assets**	**308,799**	**156,121**	**152,678**	**97.8%**
83.8%	***87.9%***	***4.1%***	***4.7%***	***Medical Loss Ratio***	***86.7%***	***88.8%***	***2.0%***	***2.3%***
8.6%	***8.1%***	***(0.5%)***	***(5.6%)***	***Admin Loss Ratio***	***8.0%***	***8.2%***	***0.1%***	***1.4%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
380	**409**	**(29)**	**(7.1%)**	**Member Months**	**1,143**	**1,215**	**(72)**	**-5.9%**
				Revenues				
2,389,641	2,574,503	(184,862)	(7.2%)	Medi-Cal Capitation Revenue	7,192,241	7,648,671	(456,430)	(6.0%)
619,175	604,107	15,068	2.5%	Medicare Part C Revenue	1,905,408	1,797,105	108,303	6.0%
186,790	145,641	41,149	28.3%	Medicare Part D Revenue	447,660	432,486	15,174	3.5%
3,195,605	**3,324,251**	**(128,646)**	**(3.9%)**	**Total Operating Revenue**	**9,545,309**	**9,878,262**	**(332,953)**	**(3.4%)**
				Medical Expenses				
896,068	962,428	66,360	6.9%	Medical Management	2,492,529	2,873,874	381,345	13.3%
663,998	759,990	95,992	12.6%	Facilities Claims	2,176,515	2,291,019	114,504	5.0%
574,305	632,121	57,816	9.1%	Professional Claims	1,686,202	1,916,404	230,202	12.0%
107,138	242,082	134,944	55.7%	Patient Transportation	342,684	731,561	388,877	53.2%
336,642	262,948	(73,694)	(28.0%)	Prescription Drugs	869,705	796,306	(73,399)	(9.2%)
(9,962)	59,646	69,608	116.7%	MLTSS	(9,873)	177,399	187,272	105.6%
4,750	17,805	13,055	73.3%	Other Expenses	14,288	54,062	39,775	73.6%
2,572,939	**2,937,020**	**364,081**	**12.4%**	**Total Medical Expenses**	**7,572,048**	**8,840,625**	**1,268,577**	**14.3%**
622,666	**387,231**	**235,435**	**60.8%**	**Gross Margin**	**1,973,260**	**1,037,637**	**935,623**	**90.2%**
				Administrative Expenses				
136,741	129,079	(7,662)	(5.9%)	Salaries, wages & employee benefits	411,123	360,259	(50,864)	(14.1%)
247	166	(81)	(48.6%)	Professional fees	410	498	88	17.7%
5,123	17,776	12,653	71.2%	Purchased services	8,165	53,328	45,163	84.7%
50,556	11,700	(38,856)	(332.1%)	Printing and postage	55,129	35,100	(20,029)	(57.1%)
2,018	2,070	52	2.5%	Depreciation & amortization	6,125	6,210	85	1.4%
3,317	3,537	220	6.2%	Other operating expenses	8,838	10,671	1,833	17.2%
1,294	4,445	3,151	70.9%	Indirect Cost Allocation, Occupancy Expense	9,513	13,260	3,747	28.3%
199,295	**168,773**	**(30,522)**	**(18.1%)**	**Total Administrative Expenses**	**499,303**	**479,326**	**(19,977)**	**(4.2%)**
				Operating Tax				
5,639	-	5,639	0.0%	Tax Revenue	16,962	-	16,962	0.0%
5,639	-	(5,639)	0.0%	Premium Tax Expense	16,962	-	(16,962)	0.0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
423,371	**218,458**	**204,913**	**93.8%**	**Change in Net Assets**	**1,473,958**	**558,311**	**915,647**	**164.0%**
80.5%	***88.4%***	***7.8%***	***8.9%***	***Medical Loss Ratio***	***79.3%***	***89.5%***	***10.2%***	***11.4%***
6.2%	***5.1%***	***(1.2%)***	***(22.8%)***	***Admin Loss Ratio***	***5.2%***	***4.9%***	***(0.4%)***	***(7.8%)***

CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
51,107	55,000	3,893	7.1%	Purchase services	139,880	165,000	25,120	15.2%
170,912	177,250	6,338	3.6%	Depreciation & amortization	512,735	531,750	19,015	3.6%
18,423	18,500	77	0.4%	Insurance expense	55,268	55,500	232	0.4%
102,600	114,916	12,316	10.7%	Repair and maintenance	300,554	344,750	44,196	12.8%
74,108	41,250	(32,858)	(79.7%)	Other Operating Expense	202,519	123,750	(78,769)	(63.7%)
(417,149)	(406,916)	10,233	2.5%	Indirect allocation, Occupancy	(1,210,957)	(1,220,750)	(9,793)	(0.8%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

OTHER INCOME STATEMENTS – SEPTEMBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.2 million, favorable to budget $0.1 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.4 million, favorable to budget $0.2 million

CalOptima
Balance Sheet
September 30, 2020

ASSETS			**LIABILITIES & NET POSITION**		
Current Assets			Current Liabilities		
	Operating Cash	$284,740,279		Accounts Payable	$78,560,784
	Investments	891,165,559		Medical Claims liability	905,686,994
	Capitation receivable	326,098,561		Accrued Payroll Liabilities	16,648,281
	Receivables - Other	49,066,605		Deferred Revenue	21,883,519
	Prepaid expenses	6,185,523		Deferred Lease Obligations	152,624
				Capitation and Withholds	151,785,687
	Total Current Assets	**1,557,256,527**		**Total Current Liabilities**	**1,174,717,888**
Capital Assets					
	Furniture & Equipment	39,890,502			
	Building/Leasehold Improvements	10,852,654			
	505 City Parkway West	51,620,226			
		102,363,381			
	Less: accumulated depreciation	(54,836,309)			
	Capital assets, net	47,527,072	Other (than pensions) post		
				employment benefits liability	25,938,821
Other Assets			Net Pension Liabilities		27,321,866
	Restricted Deposit & Other	300,000	Bldg 505 Development Rights		-
	Homeless Health Reserve	57,198,913			
	Board-designated assets:			**TOTAL LIABILITIES**	**1,227,978,574**
	Cash and Cash Equivalents	3,479,829			
	Long-term Investments	583,746,489	Deferred Inflows		
	Total Board-designated Assets	587,226,318		Excess Earnings	506,547
				OPEB 75 Difference in Experience	804,000
				Change in Assumptions	3,728,725
	Total Other Assets	644,725,231		OPEB Changes in Assumptions	1,638,000
			Net Position		
TOTAL ASSETS		**2,249,508,830**		TNE	102,433,561
				Funds in Excess of TNE	924,080,492
Deferred Outflows			**TOTAL NET POSITION**		1,026,514,054
	Contributions	1,047,297			
	Difference in Experience	4,280,308			
	Excess Earning	-			
	Changes in Assumptions	5,060,465			
	OPEB 75 Changes in Assumptions	703,000			
	Pension Contributions	570,000			
	TOTAL ASSETS & DEFERRED OUTFLOWS	**2,261,169,900**		**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,261,169,900**

CalOptima
Board Designated Reserve and TNE Analysis
as of September, 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,665,965				
	Tier 1 - MetLife	159,458,405				
	Tier 1 - Wells Capital	159,798,287				
Board-designated Reserve		479,922,656	319,097,426	499,753,563	160,825,231	(19,830,907)
TNE Requirement	Tier 2 - MetLife	107,303,662	102,433,561	102,433,561	4,870,100	4,870,100
	Consolidated:	**587,226,318**	**421,530,987**	**602,187,124**	**165,695,331**	**(14,960,806)**
	Current reserve level	*1.95*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
September 30, 2020

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	6,539,064	1,382,757
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	462,966	1,395,416
Changes in assets and liabilities:		
Prepaid expenses and other	742,026	513,686
Catastrophic reserves		
Capitation receivable	19,298,660	71,204,859
Medical claims liability	11,875,794	(11,465,026)
Deferred revenue	(455,272)	(1,540,177)
Payable to health networks	9,758,608	8,804,659
Accounts payable	(19,871,793)	3,904,338
Accrued payroll	1,414,765	3,340,217
Other accrued liabilities	(8,234)	(8,234)
Net cash provided by/(used in) operating activities	29,756,584	77,532,493
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(106,052,711)	(301,699,457)
Change in Property and Equipment	(726,258)	(2,267,918)
Change in Board designated reserves	(211,379)	(2,342,425)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	(106,990,348)	(306,309,799)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(77,233,764)	(228,777,306)
CASH AND CASH EQUIVALENTS, beginning of period	$361,974,043	513,517,584
CASH AND CASH EQUIVALENTS, end of period	**284,740,279**	**284,740,279**

BALANCE SHEET – SEPTEMBER MONTH:

ASSETS of $2.3 billion increased $9.3 million from August or 0.4%

- Operating Cash decreased $77.2 million due to the timing of cash receipts and disbursements
- Investments increased $106.1 million due to the timing of cash receipts and month-end requirements for operating cash
- Capitation Receivables decreased $21.6 million due to timing of cash receipts

LIABILITIES of $1.2 billion increased $2.7 million from August or 0.2%

- Claims Liabilities increased $11.9 million due to timing of claim payment and changes in Incurred But Not Reported (IBNR)
- Capitation and Withholds increased $9.8 million due to timing of capitation payments
- Accounts Payable decreased $20.0 million due to payment of Managed Care Organization (MCO) tax

NET ASSETS of $1.0 billion, increased $6.5 million from August or 0.6%

Homeless Health Initiative and Allocated Funds
as of September 30, 2020

		Amount
Program Commitment		$100,000,000
Funds Allocation, approved initiatives:		
Be Well OC	$11,400,000	
Recuperative Care	8,250,000	
Medical Respite	250,000	
Housing Supportive Services	2,500,000	
Clinical Field Team Start-Up & Federal Qualified Health Center (FQHC)	1,600,000	
Homeless Response Team (CalOptima)	6,000,000	
Homeless Coordination at Hospitals	10,000,000	
CalOptima Day & QI Program	1,231,087	
FQHC Mobile Unit Claims	300,000	
FQHC Mobile Unit Staff	270,000	
Home Clinic Access Program (HCAP) Expansion - Telehealth and Clinical Field Team (CFT) On Call Days	1,000,000	
Funds Allocation Total		42,801,087
Program Commitment Balance, available for new initiatives:		$57,198,913

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.
This report only lists Board approved projects.

Budget Allocation Changes
Reporting Changes for September 2020

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Maintenance HW/SW – Corporate Application SW - LexisNexis	Maintenance HW/SW – HR Corporate Application SW - SilkRoad	$12,000	To repurpose funds from LexisNexis renewal to fund shortages in SilkRoad renewal and additional licenses	2021

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
November 5, 2020

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network monitoring and audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare

- 2021 Timeliness Monitoring Project (TMP):

  On September 18, 2020, CMS announced it will conduct the industry wide Timeliness Monitoring Project (TMP) starting in January 2021. CMS will collect organization determinations, appeals and grievances (ODAG) audit universes to assess timeliness in processing Medicare Advantage (Part C) reconsiderations, as well as compliance with forwarding cases to the independent review entity (IRE). The review period requested for CalOptima will be January to March 2020. Findings may result in compliance actions, if necessary, and may have implications for the Star Ratings.

  Beginning with the 2021 TMP, CMS will no longer collect the Part D coverage determinations, appeals and grievances (CDAG) audit universes used to evaluate these measures. As in previous years, CMS will be conducting this collection of universes in three waves, with the first wave of letters requesting data being issued in January 2021.

- Calendar Year (CY) 2015 Medicare Part C National Risk Adjustment Data Validation (CON15 RADV) Audit:

  By way of background, on November 21, 2019, CMS notified CalOptima that its OneCare program was selected to participate in the CY 2015 RADV audit. On January 10, 2020, CMS released the enrollee list and opened the submission window. CMS selected a total of thirty-three (33) members for this audit.

  After suspending audit activities on March 30, 2020, due to the public health emergency, CMS resumed audit activities on September 14, 2020. The deadline for plans to submit medical records for early feedback is October 16, 2020, and the submission window closes on April 23, 2021.

Back to Agenda

- Compliance Program Effectiveness (CPE) Audit (applicable to OneCare and OneCare Connect):

  CalOptima is required to conduct an independent audit on the effectiveness of its Compliance program on an annual basis. As such, CalOptima has engaged an independent consultant to conduct the audit to ensure that its Compliance Program is administering the elements of an effective compliance program, as outlined in the CMS Medicare Parts C and D Program Audit Protocols.

  On August 17, 2020, CalOptima received an audit engagement letter from the independent auditor. The audit, while normally onsite, will be held virtually from October 12 – 19, 2020.

2. OneCare Connect

- Performance Measure Validation (PMV) for Medicare-Medicaid Plans (MMPs):

  By way of background, CMS requires MMPs to report various monitoring and performance measures, as outlined in the MMP Core Reporting Requirements and MMP State-Specific Reporting Requirements. In order to ensure MMPs' reported data are reliable, valid, complete, and comparable, CMS conducts ongoing PMV of select core and state-specific measures.

  On July 8 , 2020, CMS' contractor, HSAG/NORC, notified CalOptima of its selection for validation of two (2) performance measures:

  - MMP Core 2.1: Members with an assessment completed within 90 days of enrollment
  - MMP Core 3.2: Members with a care plan completed within 90 days of enrollment

  On September 15, 2020, CMS conducted the validation audit by webinar, and subsequently requested follow-up documentation which was submitted on October 3, 2020. CalOptima is waiting for preliminary audit results to be released.

3. PACE

- 2019 CMS Financial Audit:

  On August 13, 2020, CMS notified CalOptima PACE that it has been selected for the 2019 CMS Financial Audit. By way of background, at least one-third of Medicare Advantage Organizations (MAOs) are selected for the annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CMS contracts with several Certified Public Accountant (CPA) firms to conduct the audits.

  The CPA firms will audit and inspect any books and records of the MAO that pertain to 1) the ability of the organization to bear the risk of potential financial losses, or 2) services performed or determinations of amounts payable under the contract.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

More details will follow as soon as they become available. The audit date(s) have yet to be determined.

4. Medi-Cal

- 2020 DHCS Medical Audit:

The Department of Health Care Services' (DHCS) onsite audit of CalOptima took place from January 27, 2020 to February 7, 2020. The audit covered the review period of February 1, 2019 to January 31, 2020 and pertained to CalOptima's Medi-Cal program as well as elements of its OneCare Connect Medicaid-based services. DHCS reviewed an array of documents and data and conducted interviews with CalOptima staff as well as with a DHCS-selected delegate, Monarch HealthCare.

On August 11, 2020, the DHCS provided CalOptima with a final audit report and a formal request for a corrective action plan (CAP). The report identified seven (7) Medi-Cal findings in the audit areas of Access and Availability of Care and Member's Rights. CalOptima did not receive any findings for State Supported Services or the Cal MediConnect program. CalOptima submitted a timely CAP to the DHCS by the deadline of September 11, 2020.

As part of the CAP remediation efforts, CalOptima will provide DHCS with monthly updates on CAP implementation deliverables to ensure all milestones remain on-track. CalOptima's Compliance staff will track all milestones and deliverables until full compliance is achieved and the CAP is closed by DHCS.

B. Regulatory Notices of Non-Compliance

- CalOptima did not receive any notices of non-compliance from its regulators for the month of September 2020.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Audits: PACE

- CalOptima's Audit & Oversight (A&O) department conducted a full-scope audit of CalOptima PACE during the first quarter of 2020. PACE core operational areas were reviewed for compliance with universe, timeliness, and clinical decision-making requirements for the review period of April 1, 2019 – September 30, 2019.

- The A&O department issued a request for a corrective action plan (CAP) to PACE for thirteen (13) deficiencies related to service delivery requests, clinical appropriateness and care planning, personnel records, and appeals and grievances.

- Below is the status of the thirteen (13) deficiencies:
  - Accepted and Closed: 3 deficiencies

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- Partially Resolved: 9 deficiencies
- Not Accepted: 1 deficiency

- CAP identified as Not Accepted is due to the following reason:
  - Although PACE has submitted an updated universe to address the universe integrity issues identified as part of the audit, the universe continues to have formatting issues. A new universe was requested and pending submission to the A&O department.

- CAPs identified as Partially Revolved are unable to be closed due to the following reasons:
  - For two (2) out of the nine (9) deficiencies, the remediation activity included training for Alternative Care Setting (ACS) site coordinators; however, training has not taken place yet due to temporary site closures as a result of COVID-19.
  - Seven (7) out of the nine (9) deficiencies require validation of remediation activities for grievances and appeals. In September 2020, A&O received three (3) grievances from PACE for validation of the deficiencies. A&O's review of the three (3) grievances showed that PACE remained non-compliant with requirements for acknowledgement timeliness and complete and timely resolution of grievances.

2. Health Network Monitoring: Medi-Cal [a\]

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timely Urgent Requests	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timely Routine Requests	Timely Denials	CDM for Denials	Letter Score for Denials	Timely Modified Requests	CDM for Modified	Letter Score for Modified	Timely Deferrals	CDM for Deferrals	Letter Score for Deferrals
May 2020	90%	95%	98%	95%	95%	90%	96%	55%	84%	95%	Nothing to Report	Nothing to Report	Nothing to Report
June 2020	90%	91%	95%	91%	85%	87%	94%	79%	88%	95%	96%	75%	93%
July 2020	82%	93%	98%	91%	94%	91%	94%	81%	96%	97%	100%	98%	96%

- CalOptima's Audit & Oversight department, with approval from the Audit & Oversight Committee, suspended file review of UM Medi-Cal files for the months of March 2020 through May 2020, to allow delegates to focus their efforts and resources to serve the arising needs and ensure the safety of CalOptima members, providers and the general community as a result of the COVID – 19 pandemic. Health networks under sanction were not exempt and continued to provide files for UM's monthly monitoring. Monthly monitoring resumed in July 2020.

- Based on a focused review of select files, five (5) health networks drove the lower compliance score for timeliness. Of the fifty (50) files received from the five (5) health

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

networks, thirteen (13) files were deficient. Deficiencies for the lower scores for timeliness include the following:
- Failure to meet timeframe for decision (Urgent – 72 hours)
- Failure to meet timeframe for provider initial notification (24 hours)
- Failure to meet timeframe for provider written notification (24 hours)

➢ Based on the overall universe of Medi-Cal authorizations for June 2020, CalOptima's health networks received an aggregate compliance score of 99.92% for timely processing of routine authorization requests and a compliance score of 99.26% for timely processing of expedited authorization requests.

➢ CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
June 2020	93%	91%	97%	92%
July 2020	97%	96%	100%	93%

➢ CalOptima's Audit & Oversight department, with approval from the Audit & Oversight Committee, suspended file review of Medi-Cal claims files for the months of March 2020 through May 2020, to allow delegates to focus their efforts and resources to serve the arising needs and ensure the safety of CalOptima members, providers and the general community as a result of the COVID – 19 pandemic. Monthly monitoring resumed in July 2020.

➢ Overall compliance scores for the Medi-Cal claims monthly file reviews for July 2020 improved across all areas.

➢ Based on the overall universe of Medi-Cal claims for June 2020, CalOptima's health networks received an overall compliance score of 95.24% for timely processing of claims.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- 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.

3. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
May 2020	93%	N/A	72%	100%	84%	100%	100%	92%
June 2020	95%	100%	91%	99%	93%	100%	82%	98%
July 2020	87%	100%	91%	100%	93%	98%	100%	100%

- CalOptima's Audit & Oversight department, with approval from the Audit & Oversight Committee, suspended file review of OneCare UM files for the months of March 2020 through May 2020, to allow delegates to focus their efforts and resources to serve the arising needs and ensure the safety of CalOptima members, providers and the general community as a result of the COVID – 19 pandemic. Health networks under sanction were not exempt and continued to provide files for UM's monthly monitoring. Monthly monitoring resumed in July 2020.

- Based on a focused review of select files, four (4) health networks drove the lower compliance score for timeliness. Six (6) out of the twenty (20) files received from four (4) health networks were deficient. The deficiencies for the lower scores for timeliness include the following:
  - Failure to meet timeframe for member oral notification (expedited)
  - Failure to meet timeframe for member written notification (expedited)

- Based on the overall universe of OneCare authorization requests for June 2020, CalOptima's health networks received an overall compliance score 99.39% for timely processing of standard Part C authorization requests and an overall compliance score of 71.86% 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

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
June 2020	92%	97%	95%	97%
July 2020	100%	100%	99%	97%

  - CalOptima's Audit & Oversight department, with approval from the Audit & Oversight Committee, suspended file review of OneCare claims files for the months of March 2020 through May 2020, to allow delegates to focus their efforts and resources to serve the arising needs and ensure the safety of CalOptima members, providers and the general community as a result of the COVID – 19 pandemic. Monthly monitoring resumed in July 2020.

  - Overall compliance scores for OneCare claims improved across all areas for July 2020.

  - Based on the overall universe of OneCare claims for CalOptima's health networks for June 2020, CalOptima's health networks received the following overall compliance scores for timely processing of claims:
    – 91.14% for non-contracted clean claims paid or denied within 30 calendar days of receipt
    – 95.52% for contracted clean and unclean and non-contracted unclean claims paid or denied within 60 calendar days of receipt

  - CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as, but may not be limited to training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timeliness and accuracy of claims processing within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

4. Health Network Monitoring: OneCare Connect [a\]

- OneCare Connect Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds
May 2020	100%	N/A	84%	100%	82%	100%	92%	92%	65%	89%	97%
June 2020	96%	100%	94%	94%	93%	99%	94%	99%	95%	90%	96%
July 2020	99%	87%	89%	94%	94%	98%	86%	94%	86%	92%	100%

- CalOptima's Audit & Oversight department, with approval from the Audit & Oversight Committee, suspended file review of OneCare Connect UM files for the months of March 2020 through May 2020, to allow delegates to focus their efforts and resources to serve the arising needs and ensure the safety of CalOptima members, providers and the general community as a result of the COVID – 19 pandemic. Health networks under sanction were not exempt and continued to provide files for UM's monthly monitoring. Monthly monitoring resumed in July 2020.

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for timeliness. Six (6) of the fifteen (15) files received from the two (2) health networks were deficient. The deficiency for the lower scores for timeliness includes the following:
  - Failure to meet timeframe for provider initial notification (24 hours)

- Based on a focused review of select files, four (4) health networks drove the lower compliance letter score. Seventeen (17) files of the twenty-five (25) files received from the four (4) health networks were deficient. Deficiencies for the lower letter scores include the following**:**
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide letter with description of services in lay language
  - Failure to provide referral back to primary care provider (PCP) on denial letter

- Based on the overall universe of OneCare Connect authorization requests for June 2020, CalOptima's health networks received an overall compliance score of 99.98% for timely processing of routine authorization requests and 98.57% 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 identifying accurate root causes and

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
June 2020	91%	86%	92%	97%
July 2020	95%	95%	100%	99%

- CalOptima's Audit & Oversight department, with approval from the Audit & Oversight Committee, suspended file review of OneCare Connect claims files for the months of March through May 2020, to allow delegates to focus their efforts and resources to serve the arising needs and ensure the safety of CalOptima members, providers and the general community as a result of the COVID – 19 pandemic. Monthly monitoring resumed in July 2020.

- Overall compliance scores for OneCare Connect claims improved across all areas for the July 2020 file review.

- Based on the overall universe of OneCare Connect claims for June 2020, CalOptima's health networks received the following overall compliance scores:
  - 96.53% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt
  - 98.06% for non-contracted and contracted unclean claims paid or denied within 45 calendar days of receipt
  - 99.82% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

5. First-Tier Entity (FTE) Audits: [a\]

Type of Service	Contractual Obligations	Compliance Requirements	Information Systems Requirements	Insurance Requirements	Sub-Contractual Requirements
Printing & Fulfillment	100%	100%	100%	100%	100%
Over-the-Counter Supplemental Benefits	100%	100%	100%	100%	100%
Drug Coverage	100%	100%	100%	100%	100%

- Audit & Oversight (External) department conducted annual audits of current FTEs and readiness assessments of new FTEs to ensure compliance with applicable laws, regulations, contractual requirements, and CalOptima policies.

- All FTEs received an overall compliance score of 100%.

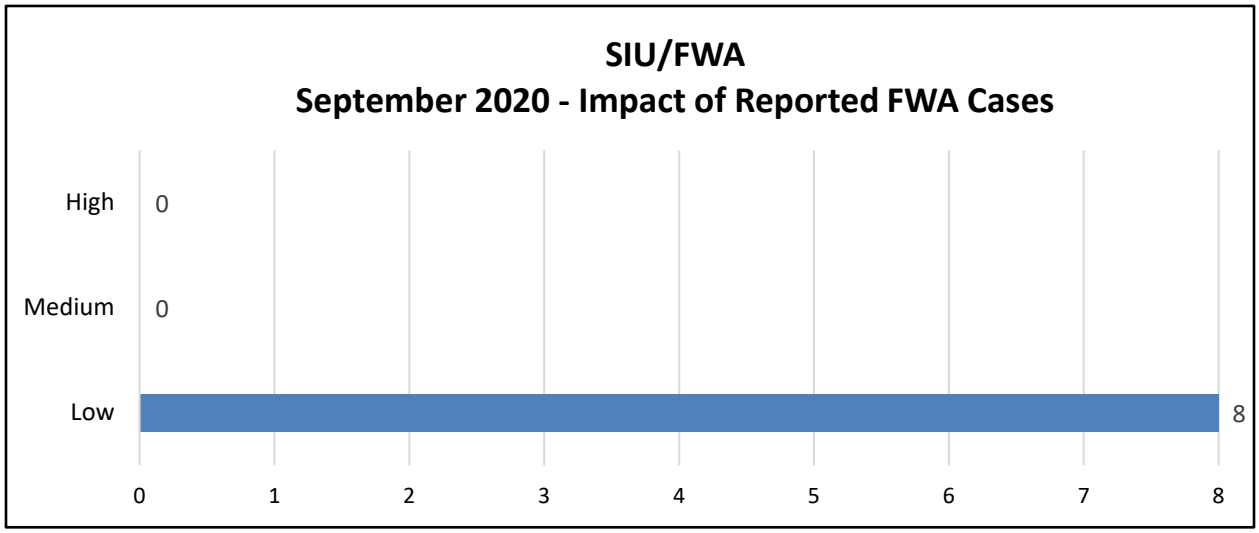
a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in September 2020)



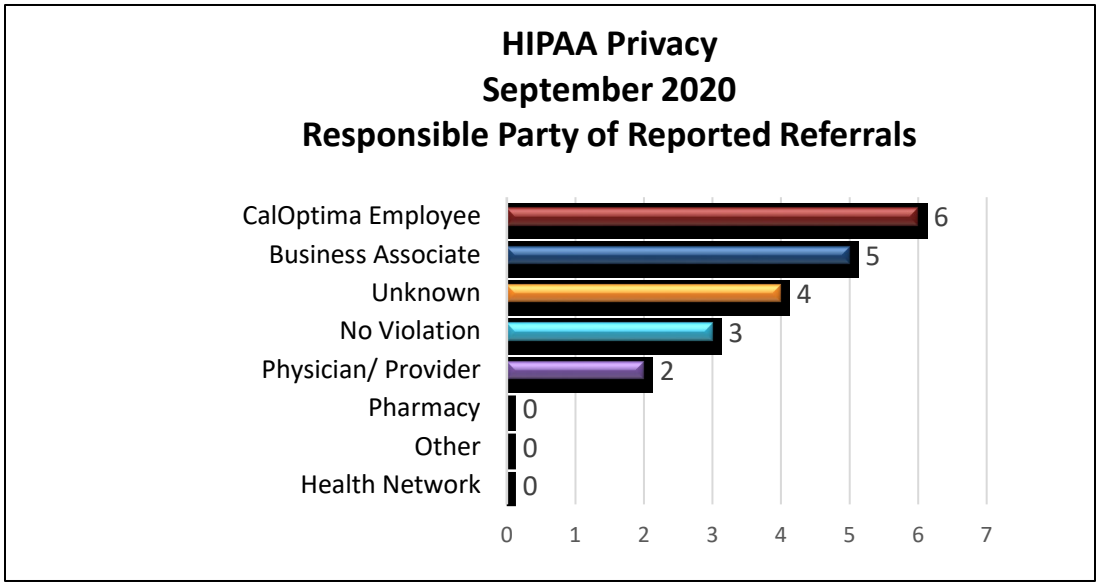


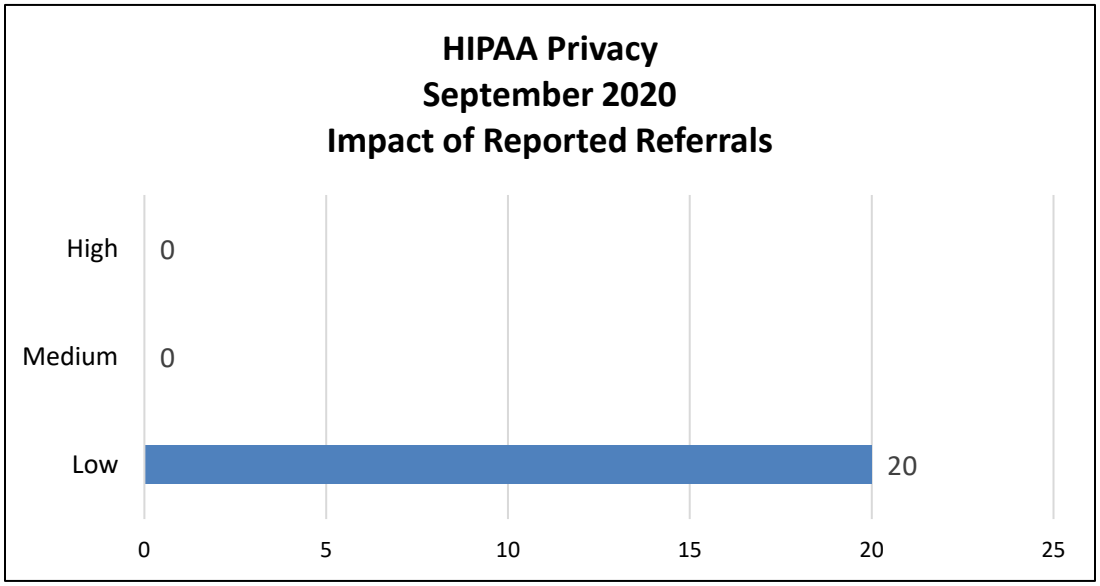
Total Number of Referrals Reported to DHCS (State)	8
Total Number of Referrals / Fraud Cases Reported to DHCS and MEDIC	0
Total Number of Referrals Reported	**8**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

E. Privacy Update: (September 2020)





Total Number of Referrals Reported to DHCS (State)	20
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**20**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

October 19, 2020

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: October Board of Directors Report

Despite months of negotiations, there is little chance that comprehensive COVID-19 relief legislation will be enacted before the election. Lawmakers are already looking ahead to the Lame Duck period, which could be very active legislatively depending on the results of the election. This report covers Congressional developments through October 18, 2020.

COVID-19 Relief Legislation

The Trump Administration and Democratic leaders have continued to negotiate a Phase 4 COVID-19 relief package, with both sides trading offers over the past month. With no deal imminent, however, a bipartisan measure is unlikely to advance prior to the election. On October 1, the House voted 214-207 to pass an updated Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES) Act (H.R. 925) that totaled about $2.2 trillion, significantly less than the original $3.4 trillion HEROES bill (H.R. 6800). Senate Republicans have not taken up the measure. Recently, House Speaker Nancy Pelosi (D-CA) dismissed an offer from Treasury Secretary Steven Mnuchin for a $1.8 trillion package, calling the proposal "insufficient." According to Democrats, the major sticking points in negotiations include provisions for COVID-19 testing and the scope of liability protections for businesses operating during the pandemic.

The Senate plans to vote the week of October 19 on a targeted, $500-billion package that includes additional funding for unemployment benefits, schools, testing, vaccine distribution, and the Paycheck Protection Program (PPP). Senate Majority Leader Mitch McConnell (R-KY) also stated that he will bring to the floor a standalone bill to replenish PPP funding. Democrats are not expected to support either measure.

Meanwhile, stimulus talks have been thrown into confusion several times over the past several weeks following remarks from President Trump. On October 6, the President appeared to scrap the relief negotiations, stating on Twitter that the Administration would be halting talks until after the election. Later, the President called for Congress to approve additional relief for the airlines and the PPP. Most recently, President Trump indicated that he has authorized Secretary Mnuchin to offer more than $1.8 trillion in negotiations, including the full $75 billion in testing funds

Back to Agenda

sought by Democrats. It is uncertain, however, whether Senate Republicans would support a larger package.

Lame Duck Outlook

The post-election "lame duck" period can sometimes be an active period legislatively, depending on how closely the election results depart from the status quo. Typically, when the election results will lead to a change in power, one of the Congressional parties prefers to wait until after the inauguration of the new President to reach any agreements. In this case, if Democrats sweep Congress and the White House, they may refrain from taking up major legislation until 2021. However, political dynamics during this period can be fluid, and sometimes the incoming majority will prefer to "clear the decks" and pass controversial legislation during the lame duck when responsibility can be shared with the other party rather than own the results during a new Congress.

The Senate is set to reconvene on November 9, while the House will return November 16. Barring a late October breakthrough, COVID-19 relief legislation will likely be on the lame duck agenda. The next COVID-19 bill could include additional provider relief, supply chain provisions, telehealth expansions, and funds for testing and contact tracing. House and Senate committees also may seek to address other health-related issues legislatively, including Medicare sequestration, surprise medical billing, price transparency, drug pricing issues, and health disparities.

Aside from the legislation that parties would like to pass, there are several "must-pass" items on the agenda, including Fiscal Year (FY) 2021 appropriations.

On October 1, President Trump signed into law a Continuing Resolution (CR) that will fund the federal government through December 11, 2020, averting a shutdown ahead of the November elections. Following negotiations with congressional Republicans and Treasury Secretary Mnuchin, the CR was revised to include farm payments and expanded nutrition assistance programs. The CR also extends through December 11 a number of Medicare and Medicaid provisions that were set to expire on November 30. These include: community health centers, the National Health Service Corps, the Teaching Health Center Graduate Medical Education Program, the Special Diabetes Program, the Certified Community Behavioral Health Centers demonstration, the Work Geographic Practice Cost Index Floor, the National Quality Forum, the Medicaid Money Follows the Person demonstration, and Medicaid spousal impoverishment protections. The CR also delays scheduled Medicaid disproportionate share hospital (DSH) payment reductions until December 11. Congress must pass another spending measure before December 11 in order to avoid a government shutdown. This measure also is likely to carry

Back to Agenda

another extension of the "health extenders," though the length of the reauthorizations is unclear at his point.

Provider Relief Fund

The Department of Health and Human Services (HHS) on October 1 announced a new $20 billion "Phase 3" General Distribution under the Provider Relief Fund (PRF). The allocation is open to Medicare, Medicaid, and CHIP providers who previously received, rejected, or accepted a General Distribution payment. Providers who already received payments equaling roughly 2 percent of annual revenue from patient care may be eligible for additional funds. An expanded group of behavioral health providers is eligible for the Phase 3 distribution, as well as previously ineligible providers, including those who began practicing between January 1 and March 31, 2020. The application deadline is November 6, 2020, and HHS is encouraging all eligible providers to apply early.

On September 19, HHS released much-awaited guidance on reporting requirements for providers who received more than $10,000 in PRF payments. Reporting for the use of PRF payments in 2020 is due by February 15, 2021, and reporting for the use of PRF payments in 2021 is due by July 31, 2021. The reporting portal will be opened in early 2021. Meanwhile, some providers have raised concern that the new guidance changes the definition of COVID-19-related "lost revenue and expenses." Previous guidance from July 19 stated that PRF payments could cover any revenue lost due to the virus, but the new guidance stipulates that PRF funds can cover only up to the amount of a provider's 2019 net patient operating income. A bipartisan group of 32 senators sent a letter to HHS Secretary Alex Azar expressing "grave concerns" about the change, and Leader McConnell also raised concern that the policy change could force hospitals to return payments they have already received under the PRF.

Executive Actions

On September 24, President Trump signed an Executive Order (EO) outlining his "America-First Healthcare Plan." Most notably, the EO directs HHS to work with Congress to develop a legislative solution for surprise billing. The EO adds that if no solution is reached by the end of the year, the HHS Secretary will take administrative actions to protect patients from balance bills. It is unclear exactly which actions the Secretary could take, but an earlier draft of the order reportedly would have required hospitals to comply with certain out-of-network billing rules as a condition of participation for Medicare. The EO states that the Administration will protect patients with pre-existing conditions and highlights other pending policies related to price transparency and prescription drugs.

Back to Agenda

The President also announced that the Administration will be sending cards worth $200 each to 35 million Medicare beneficiaries to help them cover out-of-pocket prescription drug costs. Administration officials say the details around timing and other issues are being worked out. The cards are expected to cost Medicare nearly $7 billion, an amount the White House says will be offset by savings achieved through the Administration's "most-favored-nation" drug pricing proposal.

On October 5, the President signed an EO to establish a Coronavirus Mental Health Working Group to facilitate an "all-of-government" response to mental health conditions "induced or exacerbated by the pandemic." The Working Group will include representatives from HHS and a number of other federal agencies, and will submit a report to the President within 45 days outlining a plan to better assist individuals in crisis. The order also directs federal agencies to examine their existing grant programs and consider how they can better improve mental health and reduce suicide risk during the pandemic.

Back to Agenda

CalOptima Legislative Report
By Don Gilbert and Trent Smith
October 19, 2020

The Governor recently finished working his way through the few hundred bills that made their way to his desk at the end of session. Among those bills that were signed was AB 2101, the SACRS sponsored cleanup bill we have discussed in previous updates.

Meanwhile, legislators have returned to their districts and are preparing for the November 3 election, which is fast approaching and unlike past elections, due to COVID-19, all California voters will be mailed a ballot that can be returned to election officials by mail or dropped off at designated locations. California's voter registration statistics show that a record-high 83 percent of those eligible are registered to vote and that number will climb as California allows voters to register right up until the election. Record-high voter registration, combined with the high interest generated from a Presidential election year and ease of casting a ballot means we are expecting a high and early voter turnout in California.

Below is a rundown of what you will see on November 3, with the biggest fights and most relevant propositions listed first, followed by an overview of key races in the Senate and Assembly.

Proposition 15: Split Roll Tax
Proposition 13 (1978) limited property taxes for residential, commercial, and industrial properties by basing taxes on the purchase price of the property rather than current market value. Proposition 15 would "split" the property tax roll allowing commercial and industrial properties worth more than $3 million to be assessed at current market value. This change would go into effect in 2022 but is delayed until 2025 for those properties where more than 50% of the tenants are small businesses.

Prop. 15 is expected to raise between $6.5 billion and $11.5 billion in new tax revenue with 60% allocated to local governments and 40% to K-12 schools and community colleges. Democrats and public employee unions have long bemoaned the provisions of Prop. 13 which had serious impacts on local government funding. Having raised some $20 million in support of the measure, public employee unions hope that Prop. 15, which continues to protect residents but increases the tax burden of businesses, will be palatable to voters who have historically been very wary of any change to Prop. 13.

Last Friday, Governor Newsom endorsed Prop. 15 while rejecting other proposals to tax high income earners in California. This could be a much needed boost to the proponents of Prop. 15 which is currently polling at 51% support and 40% opposition among likely voters.

At the same time, opponents led by the Small Business Roundtable are hoping sympathy for small businesses forced to close due to the pandemic will tip the scales in their favor. With $5 million in their campaign account and tens of millions more ready for independent expenditure, Prop. 15 will likely be one of the most hard fought measures on the November ballot.

Proposition 22: Classifying Gig Economy Workers
In 2018, the California Supreme Court made its landmark "Dyamex" decision (Dynamex), changing the rules governing when a worker is an independent contractor, and when they are an employee. The upshot of the decision is that the standards established by Dynamex make it far harder to classify a worker as an independent contractor. The distinction is very important as employees are entitled to the minimum wage, overtime pay, unemployment insurance, and workers' compensation.

In 2019 the Legislature passed AB 5, which effectively carved some industries and some business relationships out of Dynamex. While subsequent legislation has expanded the exemptions in AB 5, many industries continue to seek an exemption.

For app-based companies like Uber, Lyft, Postmates, and Doordash, this issue is life and death. These companies have historically classified their drivers/deliverers as independent contractors. Shortly after AB 5 passed, they qualified Prop. 22 for the ballot. Prop. 22 would treat drivers for these companies as independent contractors. While the measure would guarantee better compensation and healthcare, it falls short of what would be required if drivers were classified as employees.

Prop. 22 will be another big money fight on the ballot. The companies listed above have dumped a whopping $180 million into the campaign. Meanwhile, the opponents, particularly the Teamsters Union, have raised just shy of $5 million. While organized labor could invest more heavily in the fight via independent expenditure before the election, they will be forced to prioritize between Prop. 22 and Prop. 15.

Proposition 24: The California Privacy Rights Act (CPRA).
This initiative comes just two years after the California Consumer Privacy Act of 2018 (CCPA), was pulled off the ballot in exchange for a legislative compromise. The CCPA, as negotiated and passed by the Legislature two years ago provides rights to consumers to know the types of data being collected about them, the right to request that this data be deleted and the right to request that this data not be sold.

Among its provisions, Prop. 24 builds upon the CCPA and establishes an enforcement agency known as the California Privacy Protection Agency to implement the law and impose fines on businesses for violations. The initiative also contains a provision that prohibits the Legislature from adopting any future laws that reduce the privacy of

Back to Agenda

Californians. This provision is concerning to the business community as it essentially blocks any future attempts to amend California privacy statue.

The coalition opposing Prop. 24 is particularly interesting because it contains both privacy/consumer advocacy groups and entities from the advertising and internet industry. Privacy and consumer protection groups oppose the initiative because they do not believe it goes far enough in protecting consumer privacy, while the advertising and internet industry have concerns that the initiative's broad changes come at a time when businesses are still learning to comply with the CCPA of 2018.

Proposition 16: Affirmative action.
Prop. 16 would reverse California's voter-approved 1996 ban on affirmative action (Prop. 209). Prop. 209 prohibits public universities, schools and government agencies from using race or sex in their admissions criteria, hiring and contract decisions. While introduced earlier in the year, Prop. 16 was placed on the November ballot by legislators in the months following the murder of George Floyd. While proponents of the measure are well funded, recent polls have indicated that only 31% of likely voters supported Prop. 16 compared to 47% who oppose.

Proposition 20: Criminal Justice
In 2009, federal judges ordered California to reduce overcrowding in its prison system. In 2011, newly re-elected Governor Jerry Brown, facing both the court order and a massive state budget deficit, championed AB 109 which transferred the "supervision" of some felons to Counties and made it easier for some to qualify for parole. In an effort to further reduce prison populations, Governor Brown backed Proposition 47 in 2014. Prop. 47 made certain theft-related misdemeanors instead of felonies. Most notably, theft involving property worth $950 or less is considered a misdemeanor under Prop. 47.

The provisions of Prop. 47 were not well received by some retailers and by some in law enforcement. Assemblymember Jim Cooper, a career police officer and candidate for Sacramento County Sheriff, has championed Prop. 20 which would change the provisions of Prop. 47 to make it easier to once again prosecute certain acts of retail theft as a felony. The measure also makes changes to Prop. 56 (2016) which loosened certain parole restrictions for non-violent offenders.

Prop. 14: Stem cell research.
Prop. 14 would re-fund the California Institute for Regenerative Medicine, the state's stem cell agency, by allowing it to issue $5.5 billion in bonds for research, training and facilities construction.

Back to Agenda

Proposition 17: Parolee voting.
Prop. 17 would restore the voting rights of all people on parole if they've completed their state or federal prison terms.

Proposition 18: Voting age.
Democrats in the Legislature have made a number of changes to election years including allowing online voter registration and increased reliance on mail-in balloting coupled with the ability to allow campaign workers to return your ballot. While there are legitimate arguments for these changes, they have thus far helped increase voter turnout among Democrats. Prop. 18 was also passed by Democrats in the Legislature and would allow 17-year-olds to vote in primary elections if they would turn 18 before the general election.

Proposition 19: Property tax transfers.
Prop. 19 would allow people age 55 and older, and victims of wildfires and other disasters, to keep lower property tax rates when they move to new homes.

Proposition 21: Rent control
Backed by the Aids Healthcare Foundation, Prop. 21 would allow local governments to impose rent control on certain properties. Prop. 21 is strikingly similar to a 2018 measure rejected soundly by voters. Governor Newsom, who negotiated a statewide rent control law with legislators, property owners, realtors, and tenant groups last year, is opposing Prop. 21.

Proposition 23: Kidney Dialysis
Among other things, Prop. 23 would require a physician to be on site at a dialysis clinic when patients are being treated. Prop. 23 is another round in a running labor dispute between the two companies operating most dialysis clinics in California, and the union who has been attempting to organize their workforce since 2016. That union, SEIU-UHW, has lobbed several bills and a failed 2018 ballot measure at the companies while their dispute is ongoing.

Proposition 25: Money Bail
In 2018, the Legislature passed and the Governor signed SB 10 (Hertzberg), which would end the use of money bail in California in favor of pre trail assessments of a defendants likelihood to be a flight risk. The bill was hard fought and controversial in the Legislature with the bail industry defending its right to exist vigorously. Prop. 25 extends that fight to the November 2020 ballot.

Back to Agenda

Legislative Races

At the time of this writing, California's voter registration numbers show that there are almost twice as many registered Democrats versus Republicans and No-Party Preference (NPP) voters with 46 percent registered as Democrats and 24 percent registered as Republicans and NPP. With such a huge statewide advantage in registration and with NPP voters tending to vote for Democrats, there is an obvious reason that 75 percent of the Legislature is comprised of Democrats.

Heading into the November 3 election, the question is whether Republican legislators can maintain the status quo, gain seats, or continue the decades-long reduction in representation and relevancy.

SENATE RACES

Democrat vs. Republican

The State Senate is currently comprised of 29 Democrats and 11 Republicans. Heading into the election there is little-to-no-chance for the Republicans to pick up seats in the State Senate. As discussed below, the Democrat versus Republican races involve four Republican seats, while the Democrat held seats involve Democrats facing off against Democrats.

Senate District 29 – Senator Ling Ling Chang (R) vs. Josh Newman (D) -- This three-county (LA, Orange, San Bernardino) race is the third ballot fight involving Josh Newman and Ling Ling Chang. In 2016, Newman surprised many by defeating Chang in a close election and thereby exposed the Republicans' vulnerability in what was previously thought to be safe Republican territory. Senator Newman was then recalled by voters due to his vote to increase gas taxes in 2018 and replaced by Chang in a Special Election. Now, they are facing each other in a rematch from 2016. This time, however, the voter registration is strongly in favor of Newman who also enjoys a significant fundraising advantage having raised approximately $3 million to date.

Senate District 37 – Senator John Moorlach (R) vs. Dave Min (D) – This race, which is fully in Orange County, pits Senator John Moorlach against a former congressional aide and UC Irvine Professor, Dave Min. Moorlach, an accountant by profession, is widely recognized as a serious and thoughtful legislator on matters pertaining to the state budget and long-term debt. His views on public pension obligations raise the ire of public employee unions who have contributed heavily to his challenger. The voter registration in this district is essentially even. It would be expected that Senator Moorlach would benefit from significant name identification having previously held countywide office as the Orange County Treasurer and as a County Supervisor. However, Min will likely have a significant fundraising advantage to get his name and message out.

Back to Agenda

Senate District 23 – Rosilicie Ochoa Bogh (R) vs Abigail Medina (D) – This Inland Empire seat is currently held by a Republican Senator who declined to run for re-election. Comprising both San Bernardino and Riverside Counties, this historically Republican seat has seen significant Democratic voter registration gains in recent years and now Democrats have a registration advantage in this district. Bogh is a realtor by profession and it would be expected that the CA Realtors Association would devote financial resources to an independent expenditure effort on her behalf. Medina is a school board member and community organizer and she has received and will continue to receive significant support from the Democratic Party establishment. This is expected to be a close race.

Senate District 21 – Senator Scott Wilk (R) vs. Kipp Mueller (D) – This Los Angeles County portion of this seat stretches from Santa Clarita up through Lancaster to the High Desert communities of Apple Valley and Victorville. Again, another historically Republican seat that has undergone a change in voter registration where the Democrats now have significant 7-point registration advantage. Senator Wilk is known for his hard work representing his district and has prevailed over previous well-funded efforts to unseat him. In recent weeks, however, significant financial resources have poured into the Mueller campaign making this a race to watch on election night.

Democrat vs. Democrat
There are two races that will not impact the Democrat versus Republican split in the Senate. Though, they could impact the ideological split within the Senate Democratic Caucus between moderate Democrats and progressive Democrats.

SD 15 Dave Cortese (D) vs. Ann Ravel (D) – This race in San Jose/Silicon Valley is between two Democrats. Ann Ravel is an attorney and former election compliance official in the Obama Administration while Dave Cortese has been a locally elected county supervisor, city council member and rancher. Cortese has the support of traditional Democratic allies in organized labor and public employee unions who spent heavily in the March primary. Ravel is supported by broader base of business, community groups and enjoys editorial support for her election. While Cortese significantly outpolled Ravel in the primary, with only the two Democrats on the ballot it becomes a matter of whether Ravel can pick up the voters who voted for the Republican and NPP candidates in the primary.

SD 9 Senator Scott Wiener (D) vs. Jackie Fielder (D) – Only in San Francisco can one of the most progressive and liberal legislators in the Capitol be considered a moderate. That is the situation facing incumbent Senator Scott Wiener who is facing a challenge from the left by community activist Jackie Fielder. As a challenger to an incumbent, Fielder is getting a surprising amount of fundraising support from groups within labor and tribal gaming. We believe Senator Wiener will prevail on election

Back to Agenda

day. But, the dynamics of the race and its implications on intra party politics make it a race worth watching.

ASSEMBLY RACES

Republican Gains: Assembly District 38 – Open Seat --- Suzette Valladares (R). This Assembly seat in Santa Clarita is currently held by Democrat Christy Smith who is running for Congress in the seat that was vacated by Katie Hill. The March primary featured a slew of candidates on the Democratic side who proceeded to split the primary vote among themselves. That left the top-two vote getters as Republicans and the Republicans have rallied around Suzette Valladares, a former congressional staffer and childcare and non-profit executive director. This is the only certain partisan change in the Assembly.

Contested Seats Held by Democrats
Defending incumbents is typically a higher priority and takes the first call on available resources. The Democrats must defend three seats that were won from Republicans in 2018.

Assembly District 74 – Assemblymember Cottie Petrie-Norris (D) vs. Diane Dixon (R). This Orange County Coastal seat was one of the safest seats for the Republicans for years. Registration is now almost even. Most likely, it will be the hardest of all the seats the Democrats must defend. In 2018, as part of the anti-Trump wave, Assemblymember Petrie-Norris beat the Republican incumbent Matt Harper who, by all accounts, was an uninspired candidate and fundraiser who spent little time working in his district. Assemblymember Petrie-Norris has been the opposite. She has been district-focused, especially with issues involving the pandemic and the economy. She has raised a lot of money and has a great deal of financial support from the Democratic Party. Her opponent, Diane Dixon is a Newport Beach City Councilmember, who if not running against an incumbent, would probably be considered a front-runner and a natural fit for this seat. This race will be close.

Assembly District 76 – Assemblymember Tasha Boerner-Horvath (D) vs. Melanie Burkholder (R). Boerner-Horvath won this coastal North San Diego County seat in 2018 when the Republicans failed to place a candidate in the general election. The primary that year featured strong Republican candidates who split the vote and left the door open for the two Democrats to make the top two. It was thought that a strong Republican candidate would emerge in 2020 and easily defeat Boerner-Horvath.

However, one front running candidate dropped out during the primary leaving Burkholder as the candidate to run against Boerner-Horvath. It remains to be seen whether Burkholder, who is a faith-based counselor with views against school-mandated vaccinations, is a fit for this coastal, socially moderate district.

Back to Agenda

Assembly District 77 – Assemblymember Brian Maienschein (D) vs. June Yang-Cutter (R). Maienschein is a four-term Assemblyman from suburban San Diego who was a moderate Republican until 2019. The voters in this seat resoundingly voted against Trump in 2016 and in 2018 Maienschein barely won by 600 votes. After the election, Maienschein, saying that the Trump Republican party does not reflect his values, became a Democrat. Some would say he saw the writing on the wall – either become a Democrat or get defeated by one in 2020. Now he is running against June Yang-Cutter, an employment lawyer who is campaigning on government accountability and as a government outsider. With an approximate 3-1 fundraising advantage and registration advantage, it is expected Maienschein will prevail.

Contested Republican Held Seats

Continuing the trend started in 2018, the remaining Republican-held Assembly seats in Orange County, could turn to the Democrats in 2020. With unlimited financial resources and given the likelihood of a high Democratic turnout due to the presidential election, the Democrats could sweep up just as they did in 2018.

Assembly District 68 – Assemblymember Steven Choi (R) vs. Melissa Fox (D). This eastern Orange County seat comprises the communities of Tustin, Lake Forest, Orange and parts of Irvine is currently represented by Steven Choi who has served as a traditional smaller government, lower taxes, fewer regulations Republican. He is running again Melissa Fox who is campaigning on similar themes as a Democrat. The voter registration in this district has recently shifted to become a slight advantage for the Democrats. Fox has raised more money than any challenger in the state. This race will turn on whether Republicans in this district turn out for Trump or stay home.

Assembly District 72 – Janet Nguyen (R) vs. Deidre Nguyen (D). This seat comprising the cities of Fountain Valley, Seal Beach, and Westminster still has a slight Republican voter registration advantage. The Republican, former State Senator Janet Nguyen, has successfully won elections in races where Democrats outnumber the Republicans. Her challenger is a research scientist and City Councilmember in Garden Grove. As in all other contested races, the Democrat challenger has a significant fundraising advantage.

Assembly District 55 – Assemblymember Phil Chen (R) vs. Andrew Rodriguez (D) This three-county district bordering Orange, Los Angeles, and San Bernardino Counties has been held reliably by Republicans even as voter registration and Presidential voter sentiment has turned to Democrats. Chen, a moderate Republican who has worked at bipartisanship, is being challenged by 27-year old Andrew Rodriguez. Chen has a sizable campaign account but will still be outspent by his Democratic challenger. This could be a close race.

Back to Agenda

Assembly District 35 – Assemblymember Jordan Cunningham (R) vs. Dawn Addis (D). Because the Democrats have so much money to spend, it allows the Assembly Democrats to target seats that would otherwise look untouchable. Republican Assemblyman Jordan Cunningham in the San Luis Obispo County Assembly seat is very popular, has bipartisan appeal, and has consistently run ahead of his party registration. Yet, the Democrats have enough financial resources to mount a serious campaign against him.

Conclusion

Ballots are being received now. We believe underlying concerns over the post office and ballot counting will lead to ballots being returned early. Therefore, the ability of campaigns to influence voters in the last month will be more limited than previous elections. Further, the campaigns and party efforts to get ballots from voters and have them returned for counting will be paramount. In past elections, the Democrats have shown superiority at this practice, deemed “ballot harvesting” and have turned election night defeats into victories once all ballots were counted.

Back to Agenda

2019–20 Legislative Tracking Matrix

COVID-19 (CORONAVIRUS)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 266 McCollum	**Paycheck Protection Program and Health Care Enhancement Act:** Authorizes $483 billion to replenish segments of the CARES Act, expand coronavirus testing, and provide more support to hospitals and providers during this pandemic. Of the $483 billion, this bill includes: ■ $310 billion in funding for the Small Business Administration's PPP; ■ $10 billion for Economic Injury Disaster Loans; ■ $75 billion for the provider relief fund, managed by the Department of Health and Human Services, to cover treatment for COVID-19 patients and lost revenue from canceled elective procedures; and ■ $25 billion to research, develop, validate, manufacture, purchase, administer, and expand capacity for COVID-19 tests.	**04/24/2020** Signed into law **04/23/2020** Passed the House **04/21/2020** Passed the Senate **01/08/2019** Introduced	CalOptima: Watch
H.R. 748 Courtney	**CARES Act:** Authorizes $2.2 trillion in spending for health care and employment-related interventions. This includes: ■ $1.5 billion to support the purchase of personal protective equipment, lab testing, and other activities; ■ $127 billion to provide grants to hospitals, public entities, and nonprofits, and Medicare and Medicaid suppliers and providers to cover unreimbursed health care related expenses or lost revenues due to COVID-19; ■ $1.32 billion in supplemental funding for community health centers; ■ $955 million to support nutrition programs, home and community-based services, support for family caregivers, and expanded oversight for seniors and individuals with disabilities; ■ $945 million to support research on COVID-19; and ■ $425 million to increase mental health services.	**03/27/2020** Signed into law **03/27/2020** Passed the House **03/25/2020** Passed the Senate **01/24/2019** Introduced	CalOptima: Watch
H.R. 6201 Lowey	**Families First Coronavirus Response Act:** Allocates billions of federal funding support related to COVID-19. Funds are to be utilized for an emergency increase in the Federal Medical Assistance Percentages (FMAP) for Medicaid of 6.2%, emergency paid sick leave and unemployment insurance, COVID-19 testing at no cost, food aid and other provisions. Of note, on March 6, 2020, President Trump signed into law an emergency supplemental funding package of $8.3 billion for treating and preventing the spread of COVID-19.	**03/18/2020** Signed into law **03/17/2020** Passed the Senate **03/14/2020** Passed the House **03/11/2020** Introduced	CalOptima: Watch
H.R. 6462 Cisneros, Gallegos	**Emergency Medicaid for Coronavirus Treatment Act:** Would expand Medicaid eligibility to any American diagnosed with COVID-19 or any other illness that rises to the level of a presidential national emergency declaration. Additionally, would require Medicaid coverage for all COVID-19 treatment and testing to continue even after the national emergency is over.	**04/07/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 6666 Rush	**COVID-19 Testing, Reaching, and Contacting Everyone (TRACE) Act:** Would authorize the Centers for Disease Control and Prevention (CDC) to award grants for testing, contact tracing, monitoring, and other activities to address COVID-19. Those eligible to receive grant funding would include federally qualified health centers, nonprofit organizations, and certain hospitals and schools. Additionally, would allocate $100 billion for fiscal year 2020 for the disbursement of CDC grant funds.	**05/01/2020** Introduced	CalOptima: Watch
SB 89 Committee on Budget and Fiscal Review	**Emergency Budget Response to COVID-19:** Appropriates $500 million General Fund by amending the Budget Act of 2019. Funds will be allocated to any use related to Governor Newsom's March 4, 2020 State of Emergency regarding COVID-19. Additionally, authorizes additional appropriations related to COVID-19 in increments of $50 million, effective 72 hours following notification of the Director of Finance. Of note, the total amount appropriated to COVID-19 is not to exceed $1 billion.	**03/17/2020** Signed into law **03/16/2020** Enrolled with the Governor **01/10/2019** Introduced	CalOptima: Watch
AB 685 Reyes	**COVID-19 Workplace Exposure Notifications and Reporting:** Effective January 1, 2021, establishes employer notification and reporting requirements when an employer learns of a potential COVID-19 exposure at a worksite. Specifically, an employer must send a notice of potential exposure to all employees who were at the same worksite. The notification must include information about workers' compensation and leave options, as well as the employer's disinfection plan. In addition, the employer must report information about diagnosed employees to the local health agency within forty-eight (48) hours of learning that at least three (3) employees working at the same site have tested positive for COVID-19 within a 14-day period.	**09/17/2020** Signed into law **08/31/2020** Passed Assembly floor **08/30/2020** Passed Senate floor **06/29/2020** Introduced	CalOptima: Watch
SB 117 Committee on Budget and Fiscal Review	**Emergency Budget Response to COVID-19 at Schools:** Appropriates $100 million Proposition 98 General Fund to ensure schools are able to purchase protective equipment or supplies for cleaning school sites. Funds will be distributed by the Superintendent of Public Instruction.	**03/17/2020** Signed into law **03/16/2020** Enrolled with the Governor **01/10/2019** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 275 **Pan, Leyva**	**Personal Protective Equipment:** Would require the State Department of Public Health to establish a personal protective equipment (PPE) stockpile to ensure an adequate supply of PPE for health care workers and essential workers. Would require the stockpile to have enough supplies for no less than a 45-day pandemic or other state or local health emergency. Additionally, would require general acute care hospitals, skilled nursing facilities, integrated health systems, and licensed dialysis clinics to maintain a 45-day stockpile of PPE. Would establish the Personal Protective Equipment Advisory Committee to make recommendations to the Department of Industrial Relations and State Department of Public Health regarding necessary types and amount of PPE, procurement and supply chain resilience, storage, and other best practices.	**09/29/2020** Signed into law **08/31/2020** Passed Assembly floor **05/02/2019** Passed Senate floor **02/13/2019** Introduced	CalOptima: Watch CalPACE: Oppose
SB 1159 **Hill**	**COVID-19 Workers' Compensation Benefits:** Effective immediately and until January 1, 2023, when a qualifying employee files a workers' compensation claim for a COVID-19 diagnosis, the claim is presumed to be payable for both medical treatment and temporary disability benefits after all COVID-19-related paid sick leave has been exhausted. The employer may submit evidence to dispute the claim within forty-five (45) days of claim filing, including evidence of measures in place to reduce potential COVID-19 transmission and evidence of the employee's non-work-related risks of COVID-19 infection. Qualifying employees include: ■ Certain types of first responders and healthcare workers with a diagnosis of COVID-19. ■ Any employee who is diagnosed with COVID-19 during an outbreak of COVID-19 at the employee's worksite.	**09/17/2020** Signed into law **08/31/2020** Passed Assembly floor **06/26/2020** Passed Senate floor **04/22/2020** Introduced	CalOptima: Watch

STATE BUDGET BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 79	**Human Services:** Enacts human services trailer bills in the California 2020-2021 budget. ■ Department of Developmental Services supplemental rate increases for specified providers including, independent living programs, infant development programs, and early start specialized therapeutic services ■ In-Home Supportive Services reassessment extensions due to delays related to COVID-19 and Governor Newsom's executive state of emergency order	**06/29/2020** Signed into law **06/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 80	**Public Health:** Enacts health care trailer bills in the California 2020-2021 budget. ■ Medi-Cal managed care capitated payment rate reduction of 1.5 percent for the 18-month bridge period ■ Implementation of a Medi-Cal risk corridor for the 18-month bridge period ■ Prop 56 value-based payments and supplemental payments ■ Extension of the Medi-Cal 2020 Demonstration ■ 340B Supplemental Payment Pool for non-hospital clinics ■ Expansion of full-scope Medi-Cal to seniors, regardless of immigration status ■ Extension of coverage for COVID-19 to uninsured individuals ■ Health Care Payment Data Program ■ Reimbursement for medication-assisted treatment services	**06/29/2020** Signed into law **6/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
AB 81	**Public Health:** Enacts health care trailer bills in the California 2020-2021 budget. ■ Medi-Cal rate reimbursement methodology adjustments for skilled nursing facilities during the COVID-19 pandemic ■ Implementation of the skilled nursing facility quality assurance fee ■ County access to Mental Health Services Act funds for additional support related to COVID-19	**06/29/2020** Signed into law **6/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
AB 83	**Housing:** Enacts housing trailer bills in the California 2020-2021 budget. ■ Funding to continue Project Roomkey ■ Bypassing certain California Environmental Quality Act (CEQA) regulations related to Project Roomkey	**06/29/2020** Signed into law **6/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
AB 89	**Fiscal Year 2020-2021 California State Budget:** Enacts a $202.1 billion spending plan for Fiscal Year 2020-2021, with General Fund spending at $133.9 billion. The following included within the state budget will have a direct impact to Medi-Cal: ■ Funding to address Medi-Cal caseloads ■ Provisions to maintain Community Based Adult Services, the Multipurpose Senior Services Program, and other optional benefits ■ Funding to address the COVID-19 pandemic	**06/29/2020** Signed into law **6/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch

AFFORDABLE CARE ACT

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1425 Craig	**Patient Protection and Affordable Care Enhancement Act (PPACEA):** Would, among other things, lower health care costs through fair drug price negotiations, provide additional protections for those with preexisting health conditions, and offer 100 percent federal matching funds for states that choose to expand Medicaid under the Affordable Care Act. The bill also would reduce the Federal Medical Assistance Percentages for the fourteen remaining non-expansion states and permanently authorize the Children's Health Insurance Program.	**06/30/2020** Passed the House; Referred to the Senate **02/22/2020** Introduced	CalOptima: Watch

BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2265 Quirk-Silva	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Authorizes MHSA funds to include treatment of a substance use disorder for an individual with cooccurring mental health and substance use disorders, when that individual is already eligible to receive mental health services through an MHSA-funded program. The authorization applies across the state. Additionally, requires the county that elects to utilize MHSA funding for this purpose to report the number of people assessed for cooccurring mental health and substance use disorders and the number of those assessed who only have a substance use disorder to the Department of Health Care Services.	**09/25/2020** Signed into law **08/28/2020** Passed Senate floor **06/02/2020** Passed Assembly floor **02/14/2020** Introduced	CalOptima: Watch Orange County Board of Supervisors: Support
SB 803 Beall	**Mental Health Peer Support Services Certificate:** Creates requirements for a Certified Peer Support Specialist (PSS) certification program by July 1, 2022. Allows an individual 18 years of age or older, who has experienced a mental illness and/or a substance use disorder or is a parent or family member of such individual, to become a PSS. A PSS is able to provide non-medical specialty mental health and substance abuse support services in a county that opts in to establish a PSS certification program and funds the non-federal share of those services. This requires the Department of Health Care Services to develop and implement billing codes, reimbursement rates, and claim requirements for the PSS program. Additionally, requires the Department to include PSS as a Medi-Cal provider type and PSS services as a distinct service type in participating counties.	**09/25/2020** Signed into law **08/31/2020** Passed Assembly floor **06/24/2020** Passed Senate floor **01/08/2020** Introduced	CalOptima: Watch LHPC: Support Orange County Board of Supervisors: Support

BLOOD LEAD SCREENINGS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2276 Reyes	**Blood Lead Screening Tests Age Guidelines:** Requires the Medi-Cal managed care plan (MCP) to ensure blood lead screening tests for a Medi-Cal beneficiary at 12 and 24 months of age by doing the following: ■ Identify, on a quarterly basis, every child beneficiary that has missed a blood screening test; ■ If a test was missed, notify the beneficiary's health care provider of the requirement to perform a test and provide guidance to the parent/guardian; ■ Submit to the Department of Health Care Services, on an annual basis and upon request, a record of every beneficiary under six years of age that has missed a blood screening test, including the age at which a test was missed; and ■ If a parent/guardian declines a recommended screening, ensure that the parent/guardian signs a statement of refusal to be documented in the child's medical record.	**09/28/2020** Signed into law **08/29/2020** Passed Senate floor **06/10/2020** Passed Assembly floor **02/14/2020** Introduced	CalOptima: Watch

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4618 McBath	**Medicare Hearing Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of hearing aids for Medicare beneficiaries. Hearing aids would be provided every five years and would require a prescription from a doctor or qualified audiologist.	**1/24/2020** Passed the Committee on Energy and Commerce **10/08/2019** Introduced	CalOptima: Watch
H.R. 4650 Kelly	**Medicare Dental Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of dental health services for Medicare beneficiaries. Covered benefits would include preventive and screening services, basic and major treatments, and other care related to oral health.	**1/24/2020** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch
H.R. 4665 Schrier	**Medicare Vision Act of 2019:** No sooner than January 1, 2022, would require Medicare Part B to cover the cost of vision care for Medicare beneficiaries. Covered benefits would include routine eye exams and corrective lenses. Corrective lenses covered would be either one pair of conventional eyeglasses or contact lenses.	**1/24/2020** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch

HOMELESSNESS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1978 Correa/Lieu	**Fighting Homelessness Through Services and Housing Act:** Similar to S. 923, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of $750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of $100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to $25 million each year for up to five years. Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.	**03/28/2019** Introduced; Referred to the Committee on Financial Services	CalOptima: Watch
S. 923 Feinstein	**Fighting Homelessness Through Services and Housing Act:** Similar to H.R. 1978, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of $750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of $100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to $25 million each year for up to five years. Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.	**03/28/2019** Introduced; Referred to the Committee on Health, Education, Labor, and Pensions	CalOptima: Watch Orange County Board of Supervisors: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2746 Petrie-Norris, Gabriel	**Accountability of State Funds Used for Homelessness:** Would have required any entity that receives state funds for programs related to homelessness, including, but not limited to, the Whole-Person Care pilot program, California Work Opportunity and Responsibility to Kids (CalWORKs), or the Housing and Disability Income Advocacy Program, to submit a standardized report regarding the use of state funds. The report would have been sent annually to the state agency granting funds for the program.	**09/29/2020** Vetoed **08/30/2020** Passed Senate floor **06/10/2020** Passed Assembly floor **02/20/2020** Introduced	CalOptima: Watch

PHARMACY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2100 Wood	**Pharmacy Benefit Carve-Out (Medi-Cal Rx) Modifications:** Would have required the Department of Health Care Services to establish the Independent Prescription Drug Medical Review System (IPDMRS) for the outpatient pharmacy benefit, and to develop a framework for the system that models the requirements of the Knox-Keene Health Care Service Plan Act, no sooner than January 1, 2021. Would have required the IPDMRS to review grievances regarding any outpatient prescription drug benefit that was denied, modified, or delayed due to a finding that the service is not medically necessary or was experimental. Additionally, would have required a minimum 180 days for continuity of care for medications regardless if listed on the Medi-Cal contract drug list. Finally, would have allowed the Department to provide a disease management payment to contracted pharmacies for specialty drugs in order to ensure beneficiary access.	**09/29/2020** Vetoed **08/28/2020** Passed Senate floor **06/10/2020** Passed Assembly floor **02/05/2020** Introduced	CalOptima: Watch
SB 852 Pan	**California Affordable Drug Manufacturing Act of 2020:** Requires the California Health and Human Services Agency (CHHSA) to enter into partnerships with one or more drug companies or generic drug manufacturers, licensed by the United States Food and Drug Administration, to produce or distribute generic prescription drugs, including at least one form of insulin, in order to reduce the cost of prescription drugs. Requires CHHSA to study and report to the Legislature on the feasibility of the State directly manufacturing and selling generic prescription drugs, no later than July 1, 2023.	**09/28/2020** Signed into law **08/31/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **01/13/2020** Introduced	CalOptima: Watch CAHP: Support

PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 890 Wood	**Nurse Practitioners Scope of Practice:** Establishes the Nurse Practitioner Advisory Committee to provide recommendations and advice to the Board of Registered Nursing. Effective January 1, 2021, permits a nurse practitioner to perform specified functions without standardized procedures, including ordering, performing, and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and furnishing controlled substances, when practicing in a setting with one or more physicians. Also requires the Board of Registered Nursing to define the minimum requirements for which a nurse practitioner may transition to practice without standardized procedures within three (3) years. Effective January 1, 2023, permits a nurse practitioner to practice independently in a setting without a physician, after an additional three (3) years of practice experience.	**09/29/2020** Signed into law **08/31/2020** Passed Senate floor **01/27/2020** Passed Assembly floor **02/20/2019** Introduced	CalOptima: Watch LHPC: Support

TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4932 Thompson	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:** Similar to S. 2741, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also: ■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; ■ Remove geographic and originating site restrictions for services like mental health and emergency medical care; ■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and ■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.	**10/30/2019** Introduced; Referred to the Committees on Energy and Commerce; Ways and Means	CalOptima: Watch AHIP: Support
S. 2741 Schatz	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:** Similar to H.R. 4932, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also: ■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; ■ Remove geographic and originating site restrictions for services like mental health and emergency medical care; ■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and ■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.	**10/30/2019** Introduced; Referred to the Committee on Finance	CalOptima: Watch AHIP: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2164 Rivas, Salas	**Expanding Access to Telehealth:** Would have no longer required the first visit at a federally qualified health clinic to be an in-person visit by authorizing telehealth appointments that occur by synchronous real time or asynchronous store and forward. This would have allowed the new patient the option to utilize telehealth services and become an established patient as their first visit. This would have only applied during the COVID-19 pandemic and up to 180 days post-termination of the state of emergency.	**09/26/2020** Vetoed **08/28/2020** Passed Senate floor **06/10/2020** Passed Assembly floor **02/11/2020** Introduced	CalOptima: Watch LHPC: Support
AB 2360 Maienschein	**Mothers and Children Mental Health Support Act of 2020:** Would have created a telehealth program used to conduct mental health consultations and treatments for children, pregnant women, and postpartum persons, effective no sooner than July 1, 2021. Would have permitted telehealth services to be conducted by video or audio-only calls. Additionally, would have required the telehealth consultation appointment to be completed by a mental health clinician with expertise in providing care for pregnant, postpartum, and pediatric patients. Would have required access to a psychiatrist when deemed appropriate or requested by the treating provider.	**09/26/2020** Vetoed **08/28/2020** Passed Senate floor **06/10/2020** Passed Assembly floor **02/19/2020** Introduced	CalOptima: Watch CAHP: Oppose LHPC: Oppose

*Information in this document is subject to change as bills are still going through the stages of the legislative process.

CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: October 14, 2020

2020 Federal Legislative Dates

April 4–19	Spring recess
August 10–September 7	Summer recess
October 12–November 6	Fall recess

2020 State Legislative Dates*

**Due to COVID-19, 2020 State Legislative dates have been modified*

January 6	Legislature reconvenes
January 31	Last day for bills introduced in 2019 to pass their house of origin
February 21	Last day for legislation to be introduced
April 2–12	Spring recess
May 22	Last day for policy committees to hear and report bills to fiscal committees introduced in the Assembly
May 29	Last day for policy committees to hear and report bills to fiscal committees introduced in the Senate
May 29	Last day for policy committees to hear and report to the floor non-fiscal bills introduced in the Assembly
June 5	Last day for fiscal committees hear and report to the floor bills introduced in the Assembly
June 15	Budget bill must be passed by midnight
June 15–19	Assembly floor session only
June 19	Last day for the Assembly to pass bills in their house of origin
June 19	Last day for fiscal committees to hear and report to the floor bills introduced in the Senate
June 22–26	Senate floor session only
June 26	Last day for the Senate to pass bills in their house of origin
July 2–July 27one	Summer recess
July 31	Last day for policy committees to hear and report fiscal bills to fiscal committees
August 7	Last day for policy committees to meet and report bills to the floor
August 14	Last day for fiscal committees to report bills to the floor
August 17–31	Floor session only
August 21	Last day to amend bills on the floor
August 31	Last day for bills to be passed. Final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature
November 3	General Election
December 7	Convening of the 2021–22 session

Sources: 2020 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. We provide coverage through four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (Medicare Advantage Special Needs Plan), and the Program of All-Inclusive Care for the Elderly (PACE).

Board of Directors Meeting
November 5, 2020

CalOptima Community Outreach Summary — October 2020

Background

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events and public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors pursuant to Policy AA.1223: Participation in Community Events Involving External Entities including, but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima's staff actively participates in several community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Event Update

Preparing for back-to-school this year may be stressful for many families due to job insecurity and lack of resources as a result of the COVID-19 pandemic. Many families may not be able to provide school supplies to prepare their children for the new school year. We know that having appropriate school supplies is very important for students' academic success. Understanding this hardship, CalOptima supported a number of back-to school distribution events in August and September.

CalOptima reached thousands of families in Orange County by collaborating with community-based organizations and school districts including Santa Ana Unified School District, Magnolia School District, Anaheim Union High School District, School on Wheels, American Family Housing Foundation, Stands Up for Kids, JOYA Scholars and Buena Clinton Family and Youth Center. CalOptima branded items such as rulers, pens, pencils, erasers, bookmarks, and more were provided to these community partners for distribution to the families they serve. In addition to school supplies, fliers and brochures highlighting CalOptima's programs, services and supports were also shared with families.

For additional information or questions, contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

Back to Agenda

Summary of Public Activities
CalOptima is following all local, state and federal guidelines in an effort to prevent the spread of COVID-19 in our workplace and the community.

As of September 21, 2020, **through virtual meetings and teleconferences** CalOptima expects to participate in 28 community events, coalition and committee meetings during October.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
10/1/2020	• Continuum of Care Homeless Provider Forum (Virtual Meeting) • Garden Grove Community Collaborative Advisory Meeting (Virtual Meeting)
10/2/2020	• Mental Health Live Webinar hosted by CHOC Children's Hospital, October 2–3 (Sponsorship fee: $1,000 included opportunity to provide a welcome remark during conference, an exhibitor session, two conference registrations, 50% off any registration type for up to five attendees, registrant roster, agency's logo on website, flyer, emails, and housekeeping slides, agency's resources and flyers provided in app for attendees to view and save) • Foster and Homeless Liaison Network Meeting (Virtual Meeting)
10/3/2020	• Mental Health Live Webinar hosted by CHOC Children's Hospital, October 2–3 (Sponsorship fee: see above)
10/6/2020	• Collaborative to Assist Motel Families Meeting (Virtual Meeting)
10/7/2020	• Orange County Aging Services Collaborative General Meeting (Virtual Meeting) • Orange County Healthy Aging Initiative and Orange County Strategic Plan for Aging Healthcare Committee Meeting (Virtual Meeting) • Anaheim Human Service Providers Network Meeting (Virtual Meeting)
10/8/2020	• Orange County Advocate Fair: 2020–21 OneCare Connect Benefits hosted by Aurrera Health Group (formerly Harbage Consulting) • Buena Park Collaborative Meeting (Virtual Meeting) • Garden Grove Collaborative Meeting (Virtual Meeting) • Kid Healthy Community Advisory Council (Virtual Meeting)
10/12/2020	• Orange County Veteran's and Military Families Collaborative Meeting (Virtual Meeting) • Fullerton Collaborative Meeting (Virtual Meeting)
10/13/2020	• Orange County Cancer Coalition Meting (Virtual Meeting) • Wellness and Prevention Coalition Meeting (Virtual Meeting)
10/14/2020	• Health Care Task Force Meeting (Virtual Meeting)

Back to Agenda

10/15/2020	• Orange County Disability Coalition Meeting (Virtual Meeting) • Orange County Women's Health Project Advisory Meeting (Virtual Meeting)
10/19/2020	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting (Virtual Meeting)
10/20/2020	• Placentia Community Collaborative Meeting (Virtual Meeting) • Aging and Disability Resource Connection Advisory Committee Meeting (Virtual Meeting)
10/21/2020	• Orange County Communications Workgroup Meeting (Teleconference) • Covered Orange County Steering Committee Meeting (Teleconference)
10/22/2020	• Orange County Care Coordination for Kids Meeting (Virtual Meeting)
10/26/2020	• Stanton Collaborative Meeting (Virtual Meeting) • Community Health Research and Exchange (Virtual Meeting)

As of September 21, 2020, CalOptima expects to organize or convene four community stakeholder events, meetings or presentations through virtual meetings or teleconferences during October.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings/Presentations
10/8/2020	• Community-Based Organization Presentation to Buena Park Collaborative Members — Topic: Medi-Cal in Orange County (English Virtual Presentation)
10/15/2020	• Health Network Forum (Virtual Meeting)
10/28/2020	• Cafecito Meeting (Virtual Meeting)

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
10/9/2020	• Community-Based Organization Presentation to BPSOS Center for Community Advancement Community Workshop — Topic: CalOptima Behavioral Health Benefits (English and Vietnamese Virtual Presentation)

CalOptima provided one endorsement consistent with CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo, since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo).

Back to Agenda

1. Provide Use of CalOptima name and logo to the Coalition of Orange County Community Health Centers to promote a video contest-public awareness campaign on hygiene and safety measures to stop the spread of Coronavirus Disease 2019

Back to Agenda

CalOptima Board of Directors
Community Activities

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through participation in public activities, which meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors pursuant to Policy AA.1223: Participation in Community Events Involving External Entities, including but not limited to: the number of people the activity/event will reach; the opportunity to increase awareness of CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings, including coalitions, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima is following all local, state and federal guidelines in an effort to prevent the spread of COVID-19 in our workplace and the community.

In response to the COVID-19, CalOptima has transitioned how we engage with our community partners and is not attending in-person community collaborative meetings. In addition, most community events and resource fairs have been cancelled, postponed or have transitioned to an alternate platform in response to COVID-19. CalOptima continues its participation in community collaborative meetings and community events by attending virtual meetings and events; CalOptima also looks for additional ways to support our community partners by providing CalOptima informing materials and, if requested and criteria are met, by providing branded items. With respect to events that have been cancelled or postponed due to COVID-19 in which sponsorship or fees have already been paid, event organizers were provided the option to refund previously pre-paid participation fees or apply paid sponsorship fees to any future events,

provided the future event(s) meet the criteria set forth in Policy AA.1223 and meets eligibility requirements indicated by Board of Directors.

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

November

Date and Time	Event Title	Event Type/Audience	Staff/ Financial Participation	Location
Tuesday, 11/3 9:30–11 a.m. (Virtual format)	++ Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Thursday, 11/5 9–11 a.m. (Virtual format)	++ Continuum of Care Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Thursday, 11/5 11 a.m.–1 p.m. (Virtual format)	++ Garden Grove Community Collaborative Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	The Courtyard Center 12732 Main St. Garden Grove
Monday, 11/9 1–2:30 p.m. (Virtual format)	++ Orange County Veterans and Military Families Collaborative - Children and Family Working Group	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Monday, 11/9 2:30–3:30 p.m. (Virtual format)	++ Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 11/10 10–11:30 a.m. (Virtual format)	++Orange County Cancer Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Susan G. Komen OC 2817 McGaw Ave. Irvine

Tuesday, 11/10 3:30–5:30 p.m. (Virtual format)	++Wellness and Prevention Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	189 Avenida La Cuesta San Clemente
Thursday, 11/12 10:00–11:30 a.m. (Virtual format)	+Clinton Corner Family Campus Community Health and Resource Fair	Health/Resource Fair Open to the Public	1 Staff	Virtual Platform
Thursday, 11/12 10:00–11:30 a.m. (Virtual format)	++Buena Park Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Buena Park Community Center 6640 Beach Blvd. Buena Park
Thursday, 11/12 11:30 a.m.–12:30 p.m. (Virtual format)	++ Garden Grove Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Garden Grove Community Center 11300 Stanford Ave. Garden Grove
Thursday, 11/12 12:30–1:30 p.m. (Conference call)	++ Kid Healthy Community Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	The Hive 1725 S. Douglas Rd. Anaheim
Thursday, 11/12 3:30–5:30 p.m. (Virtual format)	++ State Council on Developmental Disabilities Regional Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	State Council on Developmental Disabilities 2000 E. Fourth St. Santa Ana
Monday, 11/16 1–4 p.m. (Virtual format)	++ OCHCA Mental Health Services Act Steering Committee	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Delhi Community Center 505 E. Central Ave. Santa Ana
Tuesday, 11/17 8:30–10 a.m. (Virtual format)	++North Orange County Senior Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	St. Jude Community Services 130 W. Bastanchury Rd. Fullerton
Tuesday, 11/17 11 a.m.–12 p.m. (Conference call)	++Placentia Community Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Placentia Library 411 Chapman Ave. Placentia
Tuesday, 11/17 1-2:30pm (Virtual format)	++Aging and Disability Resource Connection Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual Platform
Wednesday, 11/18 9–10:30 a.m. (Conference call)	++ Covered Orange County Steering Committee	Steering Committee Meeting: Open to Collaborative Members	1 Staff	The Village 1505 E. 17th St. Santa Ana

+ *Exhibitor/Attendee*
++ *Meeting Attendee*

Back to Agenda

Wednesday, 11/18 3:30–4:30 p.m. (Conference call)	++ Orange County Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Location varies
Thursday, 11/19 9–11:00 a.m. (Virtual format)	*Health Network Forum	Steering Committee Meeting: Open to Collaborative Members	10+ Staff	Virtual Platform
Thursday, 11/19 9–11:00 a.m. (Virtual format)	++ Orange County Children's Partnership Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Hall of Administration, Conference Room A 333 W. Santa Ana Blvd. Santa Ana
Thursday, 11/19 2:30–4:30 p.m. (Virtual format)	++Orange County Women's Health Project Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	The Village in Santa Ana 1505 E. 17th St. Santa Ana
Monday, 11/23 12:30–1:30 p.m. (Virtual format)	++ Stanton Collaborative	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Stanton Civic Center 7800 Katella Ave. Stanton
Thursday, 11/26 1:30-3:30 p.m. (Virtual format)	++ OC Care Coordination for Kids Collaborative	Steering Committee Meeting: Open to Collaborative Members	2 Staff	CHOC Centrum Building 1120 W. La Veta Orange

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

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

Contact
Michelle Laughlin, Executive Director Network Operations (657) 900-1116

Recommended Actions
Authorize the Chief Executive Officer with the assistance of Legal Counsel, to amend the OneCare Health Network contracts to extend the contract through December 31, 2021 and to address modified and additional terms.

Background & Discussion

Contract Extension
Each year, the Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage (MA) Plans, including CalOptima, to submit an annual bid in order to participate in the Medicare program for the upcoming year. In the annual bid, the MA Plan includes a projection of the following year's rates and costs, set based on previous year's encounter and other data, analyzed and provided by an independent third-party consultant. CMS contracts with the MA Plans for participation in the Medicare program, following approval of their benefit offerings for the new year. At the May 2020 Board meeting, the CalOptima Board of Directors authorized submission of the OneCare (OC) bid for calendar year 2021. The bid has been accepted by CMS.

CalOptima's contracts with its OneCare Health Networks are renewed on an annual basis, pending Board approval. CalOptima contracts with 11 health networks for OneCare, all on a Shared Risk basis. Contracts with each of these Health Networks currently expire on December 31, 2020. To maintain member access to care, staff is seeking Board authorization to extend these Contracts through December 31, 2021. In addition to extending the term, the amendment to the Health Network contracts will address the following issues:

Division of Financial Responsibility (DOFR)
Staff seeks authorization to implement changes to the DOFR, including reimbursement for Methadone Clinic services. Methadone Clinic services will be reimbursable by CalOptima as a Medicare-covered service.

Change Timeframe for Other Contract Terminations
Staff seeks authorization to amend the timeframe for termination without cause notice from 120 days to 180 days. This change allows for a more appropriate time frame related to activities involved with a termination including, but not limited to, reassignment of members, issuing new ID cards, member education, and operational system related changes.

Back to Agenda

Allocation of Non-Part D CMS Capitation section

The allocation of the non-Part D capitation is tied to covering the full scope of the OneCare benefit design, for example copayments. It is contingent on the annual bid to extend CalOptima's contract with CMS for the OneCare program. This non-Part D allocation is renewed annually, expiring at the end of each Calendar Year. Staff recommends extending this allocation through the end of calendar 2021

Fiscal Impact

The CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020, included OneCare Share Risk Group (OC SRG) Health Network capitation expenses of $5.2 million. The recommended action to extend the existing Health Network contracts through June 30, 2021, is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2021, through December 31, 2021, as related to the contract extension in the CalOptima FY 2021-22 Operating Budget.

The recommended action to amend the OC SRG Health Network contracts to amend contract language is budget neutral. The addition of language related to the termination without cause provision is operational in nature with no additional fiscal impact beyond what was incorporated in the CalOptima FY 2020-21 Operating Budget. The proposed update to the DOFR for methadone clinic services is not anticipated to have a material impact to CalOptima's financials.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OC members is maintained, and that contracts are aligned with current operational procedures.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Previous Board Action dated October 3, 2019; "Consider Authorizing Amendments to the OneCare Physician Medical Group Shared Risk Contracts"

/s/ Richard Sanchez — *10/28/2020*

Authorized Signature — **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI/Prospect Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western California, Inc.	1665 Scenic Ave Dr., #100	Costa Mesa	CA	92626
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Monarch Healthcare, A Medical Group, Inc.	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group, P.C.	1665 Scenic Ave Dr., Ste #100	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, #400	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates of Mid-Orange County	10855 Business Center Dr. Ste. C	Cypress	CA	90630

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
19. Consider Authorizing Amendments to the OneCare Physician Medical Group Shared Risk Contracts

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, with the assistance of Legal Counsel, to amend the OneCare Shared Risk Physician Medical Group (PMG) Contracts with AltaMed Health Services Corporation, AMVI/Prospect Medical Group, ARTA Western California Inc., Talbert Medical Group, Family Choice Medical Group Inc., Monarch Health Plan Inc., Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Talbert Medical Group P.C., and United Care Medical Group Inc. to:

1. Extend the term of the PMG Contracts through December 31, 2020.
2. Include language related to the Merit-based Incentive Payments System (MIPS) program.

Background and Discussion
CalOptima is required to submit an annual bid to Centers for Medicare & Medicaid services (CMS) for the OneCare program. At the May 2019 meeting, the CalOptima Board of Directors authorized submission of the OneCare bid for calendar year 2020. The bid has been accepted by CMS. CalOptima contracts with eight PMGs for OneCare. Each of these Contracts currently expire on December 31, 2019. Staff is seeking Board authorization to extend these Contracts through December 31, 2020.

For dates of service beginning January 1, 2019, and beyond, and in accordance with CalOptima Policies, Physician Groups are required to implement the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. MIPS provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Funding for the program is included in standard monthly capitation, with no supplemental monies being disbursed to the Health Networks. Staff is seeking Board authorization to include language in OneCare PMG Contracts supporting the provision of incentive payments for non-contracted, MIPS-eligible providers, providing covered services.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect health network capitation expenses of $5.3 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The recommended action to renew the existing health network contracts through June 30, 2020, is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extension in future operating budgets.

Back to Agenda Back to Item

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the OneCare provider network.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Action
2. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
3. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
4. CMS Release of 2019 MIPS Payment Adjustment Data File

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Attachment to October 3, 2019 Board of Directors Meeting – Agenda Item 19

AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI/Prospect 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
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
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
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

Back to Agenda Back to Item

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

Back to Agenda Back to Item

receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

---

Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850



MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

Back to Agenda Back to Item

- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

Back to Agenda Back to Item

Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Action

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCare Connect Health Network contracts to extend the term through December 31, 2021 and to address modified and additional terms.

Background

In 2014, the State launched Cal MediConnect (CMC), designed to serve members eligible for both Medicare and Medi-Cal, in a dual health plan covering medical, prescription drug, and long-term services and support. CMC was initially launched as a three-year demonstration program across eight counties in California. At the local level, CalOptima provides health care services to CMC beneficiaries in Orange County, via its OneCare Connect (OCC) program. OCC was executed with authorization through a three-way contract between CalOptima, the Department of Health Care Services (DHCS), and the Centers for Medicare & Medicaid Services (CMS). The CalOptima Board of Directors (Board) initially authorized this agreement at its December 5, 2013 meeting, with CalOptima providing OCC benefits as of July 1, 2015.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC/OCC program for an additional two years, through December 31, 2019. At its October 3, 2019 meeting, the Board authorized execution of a third Three-Way agreement, which became effective September 1, 2019. Among key changes it included the extension of the CMC Demonstration Period through December 31, 2022, renewable in one-year terms.

In support of CMC/OCC, CalOptima has contracted with its delegated Health Networks to manage health care services for OCC members as of the program's launch. At the Board's November 2018 meeting, staff received authorization to extend the Health Network contracts for one year, through December 31, 2019. On November 7, 2019, the Board authorized staff to exercise the first of three one-year (1) extension options in each of the Health Network contracts, extending them through December 31, 2020.

Discussion

Health Network Contract Extensions

With OCC entering its second year of the three-year extension granted for the Three-Way agreement with DHCS, CalOptima needs to maintain its contractual relationship with the Health Networks providing health care services to OCC members. In coordination with the extension of the

Back to Agenda

demonstration period, staff is seeking authorization to exercise a one-year extension option of the Health Networks' agreements through December 31, 2021.

Capitation Rate Change for Hospital and Shared Risk Pool Funding
Staff seeks authorization to amend the OCC Health Network contracts to adjust the Hospital capitation rates and Shared Risk Pool funding to more appropriately reflect delegated risk assigned to Health Networks, and as included in the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020.

Division of Financial Responsibility (DOFR)
Staff seeks authorization to implement changes to the DOFR, including changing coverage of Methadone Clinic services to CalOptima Responsibility as a Medicare covered service. Additionally, Worldwide Coverage has been added as a Medicare covered service.

Change Timeframe for Termination Without Cause
Staff also seeks authorization to amend the notice period for Termination Without Cause from 120 days to 180 days. This change allows for a more appropriate time frame related to activities involved with a termination including, but not limited to, reassignment of members, issuing new ID cards, member education, and operational systems-related changes.

Fiscal Impact
The CalOptima FY 2020-21 Operating Budget approved by the Board on June 4, 2020 incorporated OCC Health Network capitation expenses of $133 million, including updated Hospital capitation rates and their associated impact to Shared Risk Pool funding. The recommended action to extend the existing Health Network contracts through June 30, 2021 is a budgeted item, with no additional fiscal impact. Management plans to include revenue and expenses for OCC for the period of July 1, 2021 through December 31, 2021, as related to the contract extensions, in the CalOptima FY 2021-22 Operating Budget.

The recommended action to amend the OCC Health Network contracts to add the recommended contract language is budget neutral. The addition of language related to the termination without cause provision is operational in nature, with no anticipated fiscal impact beyond what was incorporated in the CalOptima FY 2020-21 Operating Budget. The proposed changes to the DOFR are not anticipated to have a material impact to CalOptima's financials.

Rationale for Recommendation
The recommended contract changes are intended to ensure that the contractual relationships with the Health Networks serving CalOptima's OCC members are maintained, and that contracts are aligned with current operational procedures.

Concurrence
Gary Crockett, Chief Counsel

Back to Agenda

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Previous Board Action dated November 7, 2019; "Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services."
3. Previous Board Action dated September 7, 2017; "Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program"
4. Previous Board Action dated November 7, 2019; "Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, except those associated with AltaMed Health Services Corporation, to Extend them and Incorporate Oher Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services"

/s/ Richard Sanchez — *10/28/2020*
Authorized Signature — **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr., #100	Costa Mesa	CA	92626
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group	1665 Scenic Ave Dr., Ste #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868
AltaMed Health Services	2040 Camfield Ave.	Los Angeles	CA	90040
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates	10855 Business Center Dr. Ste. C	Cypress	CA	90630
Prospect Medical Group	600 City Parkway West Ste. 800	Orange	CA	92868

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

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 amend the OneCare Connect Health Network contracts with AltaMed Health Services Corporation to:

i. Extend the OneCare Connect Health Network contract through and including December 31, 2020;
ii. Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program; and
iii. Clarify access standards for prenatal care.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (CMC) OneCare Connect beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

Cal MediConnect was launched in 2014 as a three-year demonstration program implemented across eight counties. OneCare Connect (OCC) was launched July 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated Health Networks to manage services to the network's assigned membership.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019. At its November 2018 meeting, the Board authorized CalOptima to extend the Health Network contracts for one year through December 31, 2019.
At its October 3, 2019 meeting, the Board authorized execution of the newest version of the three-way agreement, which became effective September 1, 2019. Among the key changes of the new agreement was extension of the Cal MediConnect demonstration period through, December 31, 2022, in one-year

terms. In accordance with this change, staff is seeking authorization to extend the Health Network agreements for an additional year through December 31, 2020.

Discussion

Language Provisions; Agreement with CMS and DHCS

Contract amendments will be required to include provisions to address technical revisions and any other new/revised requirements from the new Three-Way Agreement that are applicable to the OneCare Connect Health Networks. To be in compliance with the most current version of the Three-Way Agreement received from DHCS, effective September 1, 2019, staff seeks authority to amend OneCare Connect Health Network contracts to ensure contracted OCC Health Networks ensure that providers are enrolled with DHCS as Medicaid providers consistent with all Medicaid enrollment requirements. Other changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Merit-based Incentive Payment Systems (MIPS)

In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program memorandum and CalOptima Policies and Procedures, Health Networks implemented the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. This provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Payment to health networks is contingent upon annual receipt of their provider payment adjustment confirmation report, which identifies and reports all claims qualifying for MIPS payment adjustments. Health Networks are required to submit their adjustment reports on an annual basis, starting July 2020. For dates of service January 1, 2019 through December 31, 2019, payment year is 2021. Staff seeks authority to amend contracts to include language in support of the MIPS payment adjustments to the OCC Health Networks to remain in compliance with this CMS-mandated program.

Access Standards for Prenatal Care

As it relates to maternity services and access standards for prenatal care, the OneCare Connect Contract will be updated to be consistent with CalOptima's Medi-Cal Health Network contracts. The Medi-Cal Health Network contract language ensures that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for prenatal services and ensure that Physician Groups have a process in place for follow-up on Member missed appointments.

Summary of Recommendations

Staff seeks Board authorization to amend the Health Network agreements as needed to extend and add any necessary language provisions required by the Three-Way Agreement, and to include language supporting the provision for MIPS, ACOG and GEMT.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect Health Network capitation expenses of $131 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The

recommended action to renew the existing Health Network contracts through June 30, 2020 is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extensions, in the CalOptima FY 2020-21 Operating Budget.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OCC members is maintained, allows flexibility to modify OCC Health Network contracts as needed based on CalOptima's Three-Way Agreement with DHCS and CMS, support CalOptima's payment obligations under the MIPS program, and ensure access standards for prenatal care are aligned with the most current ACOG standards and guidelines.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated December 5, 2013; Consider Participation in the Cal MediConnect Program
3. Board Action dated September 7, 2017; Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program
4. Board Action dated November 1, 2018; Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts
5. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
6. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
7. CMS Release of 2019 MIPS Payment Adjustment Data File

/s/ Michael Schrader — *10/30/2019*

Authorized Signature — **Date**

AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. C. Consider Participation in the Cal MediConnect Program

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400
Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions
Consider the following required actions to participate in the Cal MediConnect Program:
1. Authorize and Direct the Chairman of the Board of Directors to Execute the Three-Way Agreement between the California DHCS, CMS and CalOptima for Cal MediConnect, subject to the interim final rates that will not harm the financial viability of CalOptima and reasonable and expected requirements related to operations and reporting;
2. Authorize and Direct the Chairman of the Board of Directors to Execute the California Department of Social Services' (CDSS) Contract for In-Home Supportive Services (IHSS);
3. Approve Revisions Related to Cal MediConnect to CalOptima's Fiscal Year (FY) 2013-14 Budget; and
4. Authorize the CEO to develop and/or update policies necessary to meet Cal MediConnect participation requirements and implement the program's benefit set.

Background
In June 2012, Senate Bill 1008 (2012) and SB 1036 (2012) authorized the Coordinated Care Initiative (CCI). The CCI is composed of two (2) key components that will work in tandem to improve care coordination and integration.

1. Cal MediConnect: No sooner than April 1, 2014, the state will begin a three (3) year federal-state demonstration program in eight (8) counties. Individuals with Medicare and Medi-Cal (i.e., dual eligible beneficiaries) will receive coordinated medical, behavioral health, institutional long-term care, and home and community based services through a single Medi-Cal managed care plan. The participating counties are: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino.

2. Managed Medi-Cal Long-Term Supports and Services (MLTSS): No sooner than April 1, 2014, all Medi-Cal beneficiaries, including dual eligible beneficiaries, will receive long-term services and supports and Medi-Cal wrap-around benefits through a Medi-Cal managed care plan. MLTSS includes institutional long-term care, Community Based Adult Services, Multipurpose Senior Services Program, and IHSS.

   As a County Organized Health System (COHS), CalOptima already serves dual eligible beneficiaries, and provides Medi-Cal wrap-around services to members. In addition, pursuant to SB 94 (2013), DHCS separated the MLTSS component from the Cal MediConnect program. Medi-Cal managed care plans will provide MLTSS as a Medi-Cal benefit to all enrollees even if Cal Medi-Connect does not move forward.

Back to Agenda Back to Item

DHCS initially proposed to implement Cal MediConnect no sooner than January 1, 2014. However, DHCS revised the timeline several times to accommodate ongoing negotiations with CMS and to resolve other implementation issues. On August 13, 2013, DHCS formally announced that Cal MediConnect will begin no sooner than April 1, 2014. Initial enrollment will occur on a passive enrollment basis for a twelve (12) month period, based on the eligible beneficiary's birthday month.

CalOptima's FY 2013-14 Operating Budget projected an increased enrollment of 27,000 members from the Cal MediConnect program through June 30, 2014. Staff will make a downward adjustment to the membership projection due to the delayed implementation date, and anticipates approximately 3,700 members will be passively enrolled each month. Staff will implement strategies to minimize the opt-out rate of the Cal MediConnect program.

The Demonstration Years for the Cal MediConnect program are as follows:

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

On May 3, 2012, your Board approved a pre-implementation budget for the CCI of $373,994 to proceed with the application process to participate in the program. The funds were used to support travel and training, consultant fees, limited term staffing, and outreach and engagement. The budget was for the period of May 3, 2012, through August 31, 2012.

On January 3, 2013, your Board approved additional funding to continue pre-implementation planning for the CCI of $615,000 for a total of $988,994. The funds were used to support professional fees and staffing. To date, approximately ninety-five percent (95%) of the pre-implementation funds have been spent. Based on Board approval, staff has completed all state and federal applications and additional requests, including but not limited to:

Key Deliverables	Date
DHCS Request for Solutions	February 23, 2012
CMS Capitated Financial Alignment Demonstration application	May 23, 2012
Proposed Model of Care	June 29, 2012
Proposed Medication Management Therapy Program	May 6, 2013
Proposed Part D Formulary	May 31, 2013
Proposed Plan Benefit Package	June 3, 2013
Revised Health Service Delivery Tables for Network Validation	June 26, 2013

Key steps and milestones for the Cal MediConnect program are as follows:

Key Steps and Milestones	Date
Finalize Memorandum of Understanding (MOU) (CMS and DHCS)	Executed March 27, 2013

Key Steps and Milestones	Date
Develop final capitation rates	Ongoing since April 23, 2013
Conduct joint readiness assessments (CMS and DHCS)	Initiated March 2013 and ongoing through December 2013 - Desk Review: April 19, 2013 - On-site visit: July 25-26, 2013 - Remote Systems Testing: October 21, 2013 - Network Validation: October 28, 2013 - Pre-Enrollment Validation: November 20, 2013 - Final Readiness report to be issued mid-December 2013
Execute MOUs with relevant county agencies	Completed in July and August 2013
Sign Three-Way contract	December 13, 2013 (electronic signature) December 16, 2013 (hard copy signature)
Sign CDSS contract for IHSS services	Mid-December 2013 (anticipated)
Finalize Plan Benefit Package in CMS system	Mid-December 2013
Implement Cal MediConnect	No sooner than April 1, 2014

On June 6, 2013, your Board approved CalOptima's FY 2013-14 Operating Budget. Staff clarified that the operating budget did not include infrastructure and implementation funding for the Duals Demonstration (i.e., the Cal MediConnect program), and that Staff would present the budget as a separate Board action.

Discussion

Both DHCS and CMS are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of Cal MediConnect. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted, as noted above, from the prior dates shared with the Board in previous meetings. Staff participated in the on-site readiness review July 25-26, 2013.

The next key step is for CalOptima to sign the Three-Way Agreement with CMS and DHCS. Recently, DHCS notified participating plans that the final date by which CMS will require execution of the Agreement is December 10, 2013. Plans, including CalOptima, received the "final" Three-Way Agreement on November 6, 2013 and were advised that they would not be able to negotiate changes to the Agreement. Although the document contains a number of terms that are currently in other program agreements, this was the first time that plans received the document which contains new Cal MediConnect program requirements, Plans had approximately one week to review the document and submit a list of "significant concerns" to the Agreement. DHCS held a conference call with plans on November 20, 2013 to discuss the comments plans submitted. On the call, the DHCS provided clarification on certain terms, but essentially reiterated that the "final" version was, in fact, final. CMS and DHCS issued interim final rates in late October for plans' thirty (30) day review. Additionally, DHCS has indicated that rates may be subject to additional minor revisions prior to the final execution of the Agreement.

Three-Way Cal MediConnect Agreement

The Agreement between DHCS, CMS, and CalOptima outlines the respective obligations for each party to implement the Cal MediConnect program in Orange County. The Agreement contains provisions for CMS

and DHCS to evaluate CalOptima's performance as a Cal MediConnect participating plan, including adherence to federal Medicare and Medicaid laws.

Below are some areas within the Agreement that will have a significant operational and financial impact:

Requirement / Area of Concern	Impact
Benefits and funding streams	The Agreement reflects continued fragmentation of Medicare and Medi-Cal benefits, services, and funding streams will pose operational challenges. Full integration will likely not occur until year 2 of the demonstration.
Care coordination	The Agreement includes extensive care coordination requirements that conflict with the existing Medicare requirements for a plan's Model of Care are included in the Agreement. Specifically, the ten (10) day timeframe to develop Individualized Care Plans (ICPs) for members after completion of the Health Risk Assessment (HRA) is insufficient.
Rate dispute process	The Agreement excludes rates from the dispute process. Requiring participating plans to waive their legal rights to dispute a rate that may be unreasonable or actuarially unsound is particularly problematic in year 2 and 3 of the demonstration.
Quality withholds	There is a lack of specific information on the quality withhold metrics, and how plans will be measured for purposes of earning back the withheld amount based on performance. The agreement lacks a process for plans to provide meaningful input on the performance metrics that will be tied to the quality withholds for each Demonstration year.
IHSS	Plans are required to assume full risk for IHSS provider payments (i.e., wages and benefits, such as health insurance). The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December. CalOptima Board of Directors would likely have to make a "go / no-go" decision on the 3-way contract for Cal MediConnect in December without the opportunity to review the CDSS contract.
After-hours call capacity	Plans cannot leverage current 24-hour Nurse Advice Lines to meet the after-hours call capacity requirement as the after-hours call service needs to be staffed either by a physician or an appropriate licensed professional under his or her supervision.

Requirement / Area of Concern	Impact
Pending contracts and regulatory guidance	The Agreement incorporates requirements to comply with unissued CMS/DHCS guidance. These references in the Agreement are broad and are not limited to indicating that the guidance will do no more than interpret current requirements under State and Federal laws.
Advisory Committee	Requires the formation of a new Advisory Committee to the Board of Directors, which must consist of not more than eleven (11) people, and no less than fifty percent (50%) of the membership of the advisory committee shall be individuals who are users of personal assistance paid for through public or private funds or recipients of IHSS services.

Other issues related to the Three-Way Agreement for Cal MediConnect include:

- Lack of specific information on IHSS;
  - Data sharing issues with the California Department of Social Services (CDSS) for IHSS; and
  - Contract terms for agreement with CDSS. The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December.

- Reporting requirements not yet specified (e.g., network adequacy, performance measures).

Revisions to CalOptima's FY 2013-14 Implementation, Operating, and Capital Budgets
Staff is submitting revisions to the FY 2013-14 Implementation, Operating, and Capital Budget to the BOD for approval with assumptions based on currently available information.

Proposed Budget 1/1/14 – 6/30/14			
	Implementation	**Operational**	**Total**
Average Monthly Enrollment	N/A	7,118	7,118
Revenue	$0	$43,130,331	$43,130,331
Medical Costs	$2,845,316	$38,414,385	$41,259,701
Administrative Costs	$2,879,267	$4,069,166	$6,948,433
Operating Income/(Loss)	($5,724,583)	$646,780	($5,077,803)
Medical Loss Ratio (MLR)	N/A	89.1%	95.7%
Administrative Loss Ratio (ALR)	N/A	9.4%	16.1%
Capital – Hardware/Software			$1,100,000

Enrollment Assumptions:
- Begins April 1, 2014 with an estimated 3,680 members
- Assumes a pre-enrollment opt-out rate of 20% and disenrollment rate of 5%

- CY 2014 enrollment will consist of FFS Medicare membership, since Medicare Advantage enrollees are allowed to stay with existing plan through Dec 2014

Revenue Assumptions:
- Bases Medicare rates on draft rates provided in October 2013
- Bases Medi-Cal rates on draft rates provided on November 20, 2013
- Estimates total revenue of $2,019.74 per member per month
- Medicare Part A/B and Part D rates utilizes a base rate and applies a risk adjustment factor (similar to OneCare revenue)
- Medi-Cal rate is a blended rate of four population cohorts: LTC, HCBS High, HCBS Low, and Community Well
- Adjusts rates for savings targets that escalate from 1.4% to 5.5% over the next three and a half years

Medical Cost Assumptions:
- Assumes an average provider capitation rate of 37.5% of Medicare Part A/B premium
- Uses current OneCare medical utilization and unit cost rates as a proxy
- Assumes an MLR of 85.3% on prescription drug benefits
- Assumes an MLR of 90.3% on Medi-Cal wrap-around benefits
- Excludes supplemental benefits with the exception of mental health and transportation services
- Includes program guidelines that require higher levels of Case Management and Health Services
- Estimates eighty-two (82) FTE's are scheduled over the remainder of the year

Administrative Cost Assumptions:
- Includes implementation costs of $5.7 million to prepare the organizations processes, policies, and staff for a targeted go-live date of April 1, 2014
- Program guidelines specify staffing requirements, such as Compliance and Customer Service
- Estimates sixty-three (63) FTE's are scheduled over the remainder of the year
- First twelve (12) months of the program will require higher than standard level of cost for initial items such as member and provider mailings as well as staff recruitment and training. These costs are staged in to occur approximately three (3) months prior to the member enrollment.

Capital Assumptions:
- Includes hardware and software required to support the increase in staffing and projected membership population

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
CCMS (Medical Database)	$ 222,300	20%
Facets Upgrades	204,300	19%
Backup Environment	67,240	6%
Core Infrastructure	58,020	5%
Data Warehouse	43,000	4%

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
Misc (Network Costs)	505,140	46%
Total	$ 1,100,000	100%

The Proposed budget includes hardware, software, and professional fees.

Next Steps:
After receipt and review of the Three-Way Agreement and analysis of the interim final rates, Staff recommends the BOD to authorize the Chairman to execute the Three-Way Agreement for CalOptima to participate in Cal MediConnect.

Concurrently, Staff will continue to prepare for the implementation of Cal MediConnect and Managed MLTSS.

Approval of the proposed actions and the Board Chair's execution of the three-way agreement with CMS and DHCS will commit CalOptima to participating in the Cal MediConnect Program.

Fiscal Impact
As outlined above, the proposed revisions to the CalOptima FY 2013-14 Implementation and Operating Budget reflect a deficit of $5.1 million and a Capital Budget of $1.1 million.

Rationale for Recommendation
The DHCS proposal to implement the CCI aligns with CalOptima's long standing commitment to better integrate acute and long term care services. This integration initiative provides CalOptima an opportunity to work with community stakeholders to design a system that fully integrates the administrative and financial responsibilities for Medi-Cal and Medicare covered services and achieve its acute and long term care integration goals.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *11/27/2013*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — *8/31/2017*
Authorized Signature — **Date**

APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

Back to Agenda Back to Item

Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

Back to Agenda Back to Item

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

Back to Agenda Back to Item

receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

---

Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850



MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

Back to Agenda Back to Item

- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

Back to Agenda Back to Item

Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: January 8, 2019

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: **Release of 2019 MIPS Payment Adjustment Data File**

The Centers for Medicare & Medicaid Services (CMS) has uploaded to the Health Plan Management System (HPMS) the Merit-based Incentive Payment System (MIPS) Payment Adjustment Data File for payment year 2019. Medicare Advantage organizations (MAOs) can use the information in the file to determine the amount of the MIPS payment adjustment that applies to their payments for Medicare Part B covered professional services furnished by out-of-network MIPS eligible clinicians.

For guidance on when and how the MIPS payments apply to MAOs' payments to MIPS eligible clinicians, please see the April 27, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments" and the November 8, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance."

File Access

The 2019 MIPS Payment Adjustment Data File has been added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). After navigating to the "Incentive Payments" section, a user may download the file by selecting "MIPS Payment Adjustment Data File" under Step One, "2019" under Step Two, and "Download" under Step Three.

Due to the sensitivity of some of the information provided in the file, only the MAO's Medicare Compliance Officer will be able to access and download it. The Compliance Officer must be a registered HPMS user in order to obtain the file.

Identifying the Applicable MIPS Adjustment Percentage

The MIPS Payment Adjustment Data File consists of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)

- MIPS adjustment percentage
- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see the attached Appendix.

An MAO can identify the applicable MIPS adjustment percentage for a MIPS eligible clinician by matching the clinician's billing TIN/NPI combination to a TIN/NPI combination in the MIPS Payment Adjustment Data File. If an exact match for the billing TIN/NPI combination does not appear in the data file, the MAO should determine whether the NPI appears in combination with another TIN and, if so, apply the MIPS adjustment percentage associated with that TIN/NPI combination. If the NPI appears in more than one TIN/NPI combination in the data file, the MAO should apply the MIPS adjustment percentage for the TIN/NPI combination that results in the greatest total payment amount.

Additional Information

If you encounter technical difficulties when downloading the MIPS Payment Adjustment Data File from HPMS, you may contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028.

If the "Incentive Payments" hyperlink does not appear in the HPMS Data Extract Facility, you must send a request for additional access to hpms_access@cms.hhs.gov. Please note that information in the MIPS Payment Adjustment Data File is considered sensitive and may require additional levels of approval.

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

Appendix

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — *8/31/2017*
Authorized Signature — **Date**

APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

Back to Agenda Back to Item

Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

Back to Agenda Back to Item

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

Back to Agenda Back to Item

receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

---

Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — *8/31/2017*
Authorized Signature — **Date**

APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, except those associated with AltaMed Health Services Corporation, to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

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 amend the OneCare Connect:

1. Health Network contracts with AMVI Care Health Network, ARTA Western California, Inc., Talbert Medical Group, P.C., Family Choice Medical Group Inc., Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network Inc., Monarch HealthCare, A Medical Group Inc., Orange County Physicians IPA Medical Group Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Prospect Health Plan Inc., and United Care Medical Group, Inc. to:
    i. Extend the OneCare Connect Health Network contract through and including December 31, 2020;
    ii. Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program;
    iii. Clarify access standards for prenatal care; and
2. Physician Hospital Consortium capitated Hospital contract with Fountain Valley Regional Hospital and Medical Center, and OneCare Connect Full-Risk Health Network contracts with Heritage Provider Network Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to incorporate the retrospective non-contracted Ground Emergency Medical Transport (GEMT) provider rate increase requirements for the July 1, 2018 through June 30, 2019 and the July 1, 2019 through June 30, 2020 periods, and the additional compensation to these Health Networks for such services.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (CMC) OneCare Connect beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

Back to Agenda Back to Item

Cal MediConnect was launched in 2014 as a three-year demonstration program implemented across eight counties. OneCare Connect (OCC) was launched July 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated Health Networks to manage services to the network's assigned membership.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019. At its November 2018 meeting, the Board authorized CalOptima to extend the Health Network contracts for one year through December 31, 2019.
At its October 3, 2019 meeting, the Board authorized execution of the newest version of the three-way agreement, which became effective September 1, 2019. Among the key changes of the new agreement was extension of the Cal MediConnect demonstration period through, December 31, 2022, in one-year terms. In accordance with this change, staff is seeking authorization to extend the Health Network agreements for an additional year through December 31, 2020.

Discussion

Language Provisions; Agreement with CMS and DHCS

Contract amendments will be required to include provisions to address technical revisions and any other new/revised requirements from the new Three-Way Agreement that are applicable to the OneCare Connect Health Networks. To be in compliance with the most current version of the Three-Way Agreement received from DHCS, effective September 1, 2019, staff seeks authority to amend OneCare Connect Health Network contracts to ensure contracted OCC Health Networks ensure that providers are enrolled with DHCS as Medicaid providers consistent with all Medicaid enrollment requirements. Other changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Merit-based Incentive Payment Systems (MIPS)

In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program memorandum and CalOptima Policies and Procedures, Health Networks implemented the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. This provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Payment to health networks is contingent upon annual receipt of their provider payment adjustment confirmation report, which identifies and reports all claims qualifying for MIPS payment adjustments. Health Networks are required to submit their adjustment reports on an annual basis, starting July 2020. For dates of service January 1, 2019 through December 31, 2019, payment year is 2021. Staff seeks authority to amend contracts to include language in support of the MIPS payment adjustments to the OCC Health Networks to remain in compliance with this CMS-mandated program.

Access Standards for Prenatal Care

As it relates to maternity services and access standards for prenatal care, the OneCare Connect Contract will be updated to be consistent with CalOptima's Medi-Cal Health Network contracts. The Medi-Cal Health Network contract language ensures that the most current standards or guidelines of the American

College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for prenatal services and ensure that Physician Groups have a process in place for follow-up on Member missed appointments.

Ground Emergency Medical Transport (GEMT)

Through the DHCS-established Quality Assurance Fee (QAF) program, retrospective payments to non-contracted Ground Emergency Medical Transport providers have been approved for the State Fiscal Years (SFY) 2018-2019 and 2019-2020, up to $400 per identified service. The program has been designated as a Medi-Cal benefit, requiring CalOptima to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support, Emergency), A0427 (Advanced Life Support, Level 1, Emergency), A0433 (Advanced Life Support, Level 2), A0434 (Specialty Care Transport), and A0225 (Neonatal Emergency Transport). Reimbursement of the difference between the base Medi-Cal rate for eligible services and the increase up to $400 is applicable toward the Physician Hospital Consortia capitated Hospital and Full-Risk Health Network contracts. Payments will be contingent on receipt of the GEMT payment adjustment confirmation report required from the health networks. Reimbursement payments will be made only in cases where the new Medi-Cal rate exceeds the Out-of-Network Medicare allowable reimbursement rate. These amendments will be renewed each year that GEMT provisions are extended past SFY 2019-2020.

Summary of Recommendations

Staff seeks Board authorization to amend the Health Network agreements as needed to extend and add any necessary language provisions required by the Three-Way Agreement, and to include language supporting the provision for MIPS, ACOG and GEMT.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect Health Network capitation expenses of $131 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The recommended action to renew the existing Health Network contracts through June 30, 2020, is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extensions, in the CalOptima FY 2020-21 Operating Budget.

The recommended action to amend the OneCare Connect Physician Hospital Consortium capitated hospital contract and OneCare Connect Full-Risk Health Network contracts to incorporate the retrospective non-contracted GEMT provider rate increase requirements for SFY 2018-19 is budget neutral. Funding for non-contracted GEMT provider payments for OneCare Connect was not included in the CalOptima FY 2019-20 Operating Budget approved by the Board on June 6, 2019. To date, staff has not received the most updated rates from DHCS. However, revenue from the State is anticipated to be sufficient to cover the estimated costs.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OCC members is maintained, allows flexibility to modify OCC Health Network contracts as needed based on CalOptima's Three-Way Agreement with DHCS and CMS, support CalOptima's payment obligations under the MIPS program, ensure access standards for prenatal care are aligned with the most current ACOG standards and guidelines, and Physician Health Consortium capitated Hospital and Full-Risk Health Network contracts support GEMT payments through the end of Fiscal year 2019-2020.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated December 5, 2013; Consider Participation in the Cal MediConnect Program
3. Board Action dated September 7, 2017; Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program
4. Board Action dated November 1, 2018; Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts
5. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
6. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
7. CMS Release of 2019 MIPS Payment Adjustment Data File
8. Board Action dated September 5, 2019; Consider Actions Related to Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services
9. California State Plan Amendment 19-0020

/s/ Michael Schrader *10/30/2019*

Authorized Signature **Date**

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
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
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

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. C. Consider Participation in the Cal MediConnect Program

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400
Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions
Consider the following required actions to participate in the Cal MediConnect Program:
1. Authorize and Direct the Chairman of the Board of Directors to Execute the Three-Way Agreement between the California DHCS, CMS and CalOptima for Cal MediConnect, subject to the interim final rates that will not harm the financial viability of CalOptima and reasonable and expected requirements related to operations and reporting;
2. Authorize and Direct the Chairman of the Board of Directors to Execute the California Department of Social Services' (CDSS) Contract for In-Home Supportive Services (IHSS);
3. Approve Revisions Related to Cal MediConnect to CalOptima's Fiscal Year (FY) 2013-14 Budget; and
4. Authorize the CEO to develop and/or update policies necessary to meet Cal MediConnect participation requirements and implement the program's benefit set.

Background
In June 2012, Senate Bill 1008 (2012) and SB 1036 (2012) authorized the Coordinated Care Initiative (CCI). The CCI is composed of two (2) key components that will work in tandem to improve care coordination and integration.

1. Cal MediConnect: No sooner than April 1, 2014, the state will begin a three (3) year federal-state demonstration program in eight (8) counties. Individuals with Medicare and Medi-Cal (i.e., dual eligible beneficiaries) will receive coordinated medical, behavioral health, institutional long-term care, and home and community based services through a single Medi-Cal managed care plan. The participating counties are: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino.

2. Managed Medi-Cal Long-Term Supports and Services (MLTSS): No sooner than April 1, 2014, all Medi-Cal beneficiaries, including dual eligible beneficiaries, will receive long-term services and supports and Medi-Cal wrap-around benefits through a Medi-Cal managed care plan. MLTSS includes institutional long-term care, Community Based Adult Services, Multipurpose Senior Services Program, and IHSS.

   As a County Organized Health System (COHS), CalOptima already serves dual eligible beneficiaries, and provides Medi-Cal wrap-around services to members. In addition, pursuant to SB 94 (2013), DHCS separated the MLTSS component from the Cal MediConnect program. Medi-Cal managed care plans will provide MLTSS as a Medi-Cal benefit to all enrollees even if Cal Medi-Connect does not move forward.

Back to Agenda Back to Item

DHCS initially proposed to implement Cal MediConnect no sooner than January 1, 2014. However, DHCS revised the timeline several times to accommodate ongoing negotiations with CMS and to resolve other implementation issues. On August 13, 2013, DHCS formally announced that Cal MediConnect will begin no sooner than April 1, 2014. Initial enrollment will occur on a passive enrollment basis for a twelve (12) month period, based on the eligible beneficiary's birthday month.

CalOptima's FY 2013-14 Operating Budget projected an increased enrollment of 27,000 members from the Cal MediConnect program through June 30, 2014. Staff will make a downward adjustment to the membership projection due to the delayed implementation date, and anticipates approximately 3,700 members will be passively enrolled each month. Staff will implement strategies to minimize the opt-out rate of the Cal MediConnect program.

The Demonstration Years for the Cal MediConnect program are as follows:

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

On May 3, 2012, your Board approved a pre-implementation budget for the CCI of $373,994 to proceed with the application process to participate in the program. The funds were used to support travel and training, consultant fees, limited term staffing, and outreach and engagement. The budget was for the period of May 3, 2012, through August 31, 2012.

On January 3, 2013, your Board approved additional funding to continue pre-implementation planning for the CCI of $615,000 for a total of $988,994. The funds were used to support professional fees and staffing. To date, approximately ninety-five percent (95%) of the pre-implementation funds have been spent. Based on Board approval, staff has completed all state and federal applications and additional requests, including but not limited to:

Key Deliverables	Date
DHCS Request for Solutions	February 23, 2012
CMS Capitated Financial Alignment Demonstration application	May 23, 2012
Proposed Model of Care	June 29, 2012
Proposed Medication Management Therapy Program	May 6, 2013
Proposed Part D Formulary	May 31, 2013
Proposed Plan Benefit Package	June 3, 2013
Revised Health Service Delivery Tables for Network Validation	June 26, 2013

Key steps and milestones for the Cal MediConnect program are as follows:

Key Steps and Milestones	Date
Finalize Memorandum of Understanding (MOU) (CMS and DHCS)	Executed March 27, 2013

Key Steps and Milestones	Date
Develop final capitation rates	Ongoing since April 23, 2013
Conduct joint readiness assessments (CMS and DHCS)	Initiated March 2013 and ongoing through December 2013 - Desk Review: April 19, 2013 - On-site visit: July 25-26, 2013 - Remote Systems Testing: October 21, 2013 - Network Validation: October 28, 2013 - Pre-Enrollment Validation: November 20, 2013 - Final Readiness report to be issued mid-December 2013
Execute MOUs with relevant county agencies	Completed in July and August 2013
Sign Three-Way contract	December 13, 2013 (electronic signature) December 16, 2013 (hard copy signature)
Sign CDSS contract for IHSS services	Mid-December 2013 (anticipated)
Finalize Plan Benefit Package in CMS system	Mid-December 2013
Implement Cal MediConnect	No sooner than April 1, 2014

On June 6, 2013, your Board approved CalOptima's FY 2013-14 Operating Budget. Staff clarified that the operating budget did not include infrastructure and implementation funding for the Duals Demonstration (i.e., the Cal MediConnect program), and that Staff would present the budget as a separate Board action.

Discussion

Both DHCS and CMS are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of Cal MediConnect. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted, as noted above, from the prior dates shared with the Board in previous meetings. Staff participated in the on-site readiness review July 25-26, 2013.

The next key step is for CalOptima to sign the Three-Way Agreement with CMS and DHCS. Recently, DHCS notified participating plans that the final date by which CMS will require execution of the Agreement is December 10, 2013. Plans, including CalOptima, received the "final" Three-Way Agreement on November 6, 2013 and were advised that they would not be able to negotiate changes to the Agreement. Although the document contains a number of terms that are currently in other program agreements, this was the first time that plans received the document which contains new Cal MediConnect program requirements, Plans had approximately one week to review the document and submit a list of "significant concerns" to the Agreement. DHCS held a conference call with plans on November 20, 2013 to discuss the comments plans submitted. On the call, the DHCS provided clarification on certain terms, but essentially reiterated that the "final" version was, in fact, final. CMS and DHCS issued interim final rates in late October for plans' thirty (30) day review. Additionally, DHCS has indicated that rates may be subject to additional minor revisions prior to the final execution of the Agreement.

Three-Way Cal MediConnect Agreement

The Agreement between DHCS, CMS, and CalOptima outlines the respective obligations for each party to implement the Cal MediConnect program in Orange County. The Agreement contains provisions for CMS

and DHCS to evaluate CalOptima's performance as a Cal MediConnect participating plan, including adherence to federal Medicare and Medicaid laws.

Below are some areas within the Agreement that will have a significant operational and financial impact:

Requirement / Area of Concern	Impact
Benefits and funding streams	The Agreement reflects continued fragmentation of Medicare and Medi-Cal benefits, services, and funding streams will pose operational challenges. Full integration will likely not occur until year 2 of the demonstration.
Care coordination	The Agreement includes extensive care coordination requirements that conflict with the existing Medicare requirements for a plan's Model of Care are included in the Agreement. Specifically, the ten (10) day timeframe to develop Individualized Care Plans (ICPs) for members after completion of the Health Risk Assessment (HRA) is insufficient.
Rate dispute process	The Agreement excludes rates from the dispute process. Requiring participating plans to waive their legal rights to dispute a rate that may be unreasonable or actuarially unsound is particularly problematic in year 2 and 3 of the demonstration.
Quality withholds	There is a lack of specific information on the quality withhold metrics, and how plans will be measured for purposes of earning back the withheld amount based on performance. The agreement lacks a process for plans to provide meaningful input on the performance metrics that will be tied to the quality withholds for each Demonstration year.
IHSS	Plans are required to assume full risk for IHSS provider payments (i.e., wages and benefits, such as health insurance). The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December. CalOptima Board of Directors would likely have to make a "go / no-go" decision on the 3-way contract for Cal MediConnect in December without the opportunity to review the CDSS contract.
After-hours call capacity	Plans cannot leverage current 24-hour Nurse Advice Lines to meet the after-hours call capacity requirement as the after-hours call service needs to be staffed either by a physician or an appropriate licensed professional under his or her supervision.

Requirement / Area of Concern	Impact
Pending contracts and regulatory guidance	The Agreement incorporates requirements to comply with unissued CMS/DHCS guidance. These references in the Agreement are broad and are not limited to indicating that the guidance will do no more than interpret current requirements under State and Federal laws.
Advisory Committee	Requires the formation of a new Advisory Committee to the Board of Directors, which must consist of not more than eleven (11) people, and no less than fifty percent (50%) of the membership of the advisory committee shall be individuals who are users of personal assistance paid for through public or private funds or recipients of IHSS services.

Other issues related to the Three-Way Agreement for Cal MediConnect include:

- Lack of specific information on IHSS;
  - Data sharing issues with the California Department of Social Services (CDSS) for IHSS; and
  - Contract terms for agreement with CDSS. The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December.

- Reporting requirements not yet specified (e.g., network adequacy, performance measures).

Revisions to CalOptima's FY 2013-14 Implementation, Operating, and Capital Budgets
Staff is submitting revisions to the FY 2013-14 Implementation, Operating, and Capital Budget to the BOD for approval with assumptions based on currently available information.

Proposed Budget 1/1/14 – 6/30/14			
	Implementation	**Operational**	**Total**
Average Monthly Enrollment	N/A	7,118	7,118
Revenue	$0	$43,130,331	$43,130,331
Medical Costs	$2,845,316	$38,414,385	$41,259,701
Administrative Costs	$2,879,267	$4,069,166	$6,948,433
Operating Income/(Loss)	($5,724,583)	$646,780	($5,077,803)
Medical Loss Ratio (MLR)	N/A	89.1%	95.7%
Administrative Loss Ratio (ALR)	N/A	9.4%	16.1%
Capital – Hardware/Software			$1,100,000

Enrollment Assumptions:
- Begins April 1, 2014 with an estimated 3,680 members
- Assumes a pre-enrollment opt-out rate of 20% and disenrollment rate of 5%

- CY 2014 enrollment will consist of FFS Medicare membership, since Medicare Advantage enrollees are allowed to stay with existing plan through Dec 2014

Revenue Assumptions:
- Bases Medicare rates on draft rates provided in October 2013
- Bases Medi-Cal rates on draft rates provided on November 20, 2013
- Estimates total revenue of $2,019.74 per member per month
- Medicare Part A/B and Part D rates utilizes a base rate and applies a risk adjustment factor (similar to OneCare revenue)
- Medi-Cal rate is a blended rate of four population cohorts: LTC, HCBS High, HCBS Low, and Community Well
- Adjusts rates for savings targets that escalate from 1.4% to 5.5% over the next three and a half years

Medical Cost Assumptions:
- Assumes an average provider capitation rate of 37.5% of Medicare Part A/B premium
- Uses current OneCare medical utilization and unit cost rates as a proxy
- Assumes an MLR of 85.3% on prescription drug benefits
- Assumes an MLR of 90.3% on Medi-Cal wrap-around benefits
- Excludes supplemental benefits with the exception of mental health and transportation services
- Includes program guidelines that require higher levels of Case Management and Health Services
- Estimates eighty-two (82) FTE's are scheduled over the remainder of the year

Administrative Cost Assumptions:
- Includes implementation costs of $5.7 million to prepare the organizations processes, policies, and staff for a targeted go-live date of April 1, 2014
- Program guidelines specify staffing requirements, such as Compliance and Customer Service
- Estimates sixty-three (63) FTE's are scheduled over the remainder of the year
- First twelve (12) months of the program will require higher than standard level of cost for initial items such as member and provider mailings as well as staff recruitment and training. These costs are staged in to occur approximately three (3) months prior to the member enrollment.

Capital Assumptions:
- Includes hardware and software required to support the increase in staffing and projected membership population

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
CCMS (Medical Database)	$ 222,300	20%
Facets Upgrades	204,300	19%
Backup Environment	67,240	6%
Core Infrastructure	58,020	5%
Data Warehouse	43,000	4%

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
Misc (Network Costs)	505,140	46%
Total	$ 1,100,000	100%

The Proposed budget includes hardware, software, and professional fees.

Next Steps:
After receipt and review of the Three-Way Agreement and analysis of the interim final rates, Staff recommends the BOD to authorize the Chairman to execute the Three-Way Agreement for CalOptima to participate in Cal MediConnect.

Concurrently, Staff will continue to prepare for the implementation of Cal MediConnect and Managed MLTSS.

Approval of the proposed actions and the Board Chair's execution of the three-way agreement with CMS and DHCS will commit CalOptima to participating in the Cal MediConnect Program.

Fiscal Impact
As outlined above, the proposed revisions to the CalOptima FY 2013-14 Implementation and Operating Budget reflect a deficit of $5.1 million and a Capital Budget of $1.1 million.

Rationale for Recommendation
The DHCS proposal to implement the CCI aligns with CalOptima's long standing commitment to better integrate acute and long term care services. This integration initiative provides CalOptima an opportunity to work with community stakeholders to design a system that fully integrates the administrative and financial responsibilities for Medi-Cal and Medicare covered services and achieve its acute and long term care integration goals.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *11/27/2013*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — *8/31/2017*
Authorized Signature — **Date**

APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

Back to Agenda Back to Item

Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

Back to Agenda Back to Item

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

Back to Agenda Back to Item

receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

---

Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850



MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

Back to Agenda Back to Item

- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

Back to Agenda Back to Item

Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: January 8, 2019

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: **Release of 2019 MIPS Payment Adjustment Data File**

The Centers for Medicare & Medicaid Services (CMS) has uploaded to the Health Plan Management System (HPMS) the Merit-based Incentive Payment System (MIPS) Payment Adjustment Data File for payment year 2019. Medicare Advantage organizations (MAOs) can use the information in the file to determine the amount of the MIPS payment adjustment that applies to their payments for Medicare Part B covered professional services furnished by out-of-network MIPS eligible clinicians.

For guidance on when and how the MIPS payments apply to MAOs' payments to MIPS eligible clinicians, please see the April 27, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments" and the November 8, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance."

File Access

The 2019 MIPS Payment Adjustment Data File has been added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). After navigating to the "Incentive Payments" section, a user may download the file by selecting "MIPS Payment Adjustment Data File" under Step One, "2019" under Step Two, and "Download" under Step Three.

Due to the sensitivity of some of the information provided in the file, only the MAO's Medicare Compliance Officer will be able to access and download it. The Compliance Officer must be a registered HPMS user in order to obtain the file.

Identifying the Applicable MIPS Adjustment Percentage

The MIPS Payment Adjustment Data File consists of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)

- MIPS adjustment percentage
- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see the attached Appendix.

An MAO can identify the applicable MIPS adjustment percentage for a MIPS eligible clinician by matching the clinician's billing TIN/NPI combination to a TIN/NPI combination in the MIPS Payment Adjustment Data File. If an exact match for the billing TIN/NPI combination does not appear in the data file, the MAO should determine whether the NPI appears in combination with another TIN and, if so, apply the MIPS adjustment percentage associated with that TIN/NPI combination. If the NPI appears in more than one TIN/NPI combination in the data file, the MAO should apply the MIPS adjustment percentage for the TIN/NPI combination that results in the greatest total payment amount.

Additional Information

If you encounter technical difficulties when downloading the MIPS Payment Adjustment Data File from HPMS, you may contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028.

If the "Incentive Payments" hyperlink does not appear in the HPMS Data Extract Facility, you must send a request for additional access to hpms_access@cms.hhs.gov. Please note that information in the MIPS Payment Adjustment Data File is considered sensitive and may require additional levels of approval.

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

Appendix

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

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

Back to Agenda
Back to Agenda
Back to Item

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.

Back to Agenda
Back to Agenda
Back to Item

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**

Back to Agenda
Back to Agenda Back to Item

Attachment to the September 5, 2019 Board of Directors Meeting – Agenda Item 9

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

Back to Agenda
Back to Agenda
Back to Item

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Regional Operations Group

September 6, 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) 19-0020, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 30, 2019. SPA 19-0020 continues the Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers to Medi-Cal patients from July 1, 2019 to June 30, 2020.

The effective date of this SPA is July 1, 2019. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard C. Allen
Director
Western Regional Operations Group

cc: Jacey Cooper, California Department of Health Care Services (DHCS)
Lindy Harrington, DHCS
Connie Florez, DHCS
Michelle Tamai, DHCS
Adam Neighbours, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

Back to Agenda Back to Item

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 19 — 00 20

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Title 42 CFR 447 Subpart F

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ 2019 $ $4,809,054
b. FFY ~~2019~~ 2020 $ $14,427,163

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 29, Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Supplement 29, Attachment 4.19-B, pages 1-2

10. SUBJECT OF AMENDMENT

One-year reimbursement rate add-on for ground emergency medical transports with dates of service between July 1, 2019 and June 30, 2020.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Mari Cantwell

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: July 30, 2019

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: July 30, 2019

18. DATE APPROVED: September 6, 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Richard C. Allen

22. TITLE: Director, Center for Medicaid & CHIP Services, Regional Operations Group

23. REMARKS

For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

Box 7: CMS pen and ink change to update years per state response to informal questions dated 8/21/19.

FORM CMS-179 (07/92)

Instructions on Back

Back to Agenda Back to Item

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, as described below, effective July 1, 2018 through June 30, 2019 and July 1, 2019 through June 30, 2020. 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 BLS Emergency, A0427 ALS Emergency, A0433 ALS2, A0434 Specialty Care Transport, and A0225 Neonatal Emergency Transport. An "emergency medical transport" does not occur when, following evaluation of a patient, a transport is not provided.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for SFY 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 is $339.00. The add-on is paid on a per-claim basis.

For SFY 2019-20, the reimbursement rate add-on is fixed. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, A0433, and A0434 is $339.00, and for CPT Code A0225 is $400.72. The add-on is paid for each eligible CPT Code on a per-claim basis.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

Service Code	Description	Current Payment*	Add On Amount	Resulting Total Payment
A0429	Basic Life Support, Emergency	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00
A0434	Specialty Care Transport	$118.20	$220.80	$339.00
A0225	Neonatal Emergency Transport	$179.92	$220.80	$400.72

*These are the base rates associated with these codes, but are subject to further adjustments pursuant to the State Plan.

The resulting total payment amount as listed in the table above for the applicable CPT Code is considered the Rogers rate, which managed care organizations shall pay noncontract managed care emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code, for each state fiscal year the FFS reimbursement rate add-on is effective.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8849

Recommended Actions

1. Authorize reallocation of $2.5 million in Intergovernmental Transfer (IGT) 6 and 7 funds allocated for housing supportive services to the County of Orange's Homekey Program for CalOptima Medi-Cal members;
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to:
    a. Issue a commitment letter to the County of Orange to provide $2.5 million in grant funds for the County's Homekey Program in exchange for at least three years of enhanced services provided to CalOptima Medi-Cal members at the Homekey Program sites; and
    b. Enter into a Grant Agreement with the County of Orange to provide $2.5 million in grant funds for the County's Homekey Program initiative in exchange for at least three years of enhanced services provided to CalOptima Medi-Cal members at the Homekey Program sites.

Background

CalOptima received payment from the Department of Health Care Services (DHCS) for Intergovernmental Transfers (IGTs) 6 and 7 transactions in two installments (September 17 and May 2018); CalOptima's total share was approximately $31.1 million. IGTs are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. DHCS approved use of IGT 6 and 7 funds to provide enhanced services to CalOptima Medi-Cal members in the following areas: opioid overuse, homeless health care access, children's mental health, adult mental health, childhood obesity, strengthening the safety net, children's health, older adult health and other areas as identified by the Member Health Needs Assessment conducted in 2017 and published in 2018.

During the August 3, 2017 CalOptima Board of Directors (Board) meeting, the following four focus areas were approved to support community-based organizations through one-time competitive grants: 1) Opioid and Other Substance Overuse; 2) Children's Mental Health; 3) Homeless Health; and, 4) Community needs identified by the CalOptima Member Health Needs Assessment. While community proposals were being considered, on August 2, 2018, the Board made a grant allocation of up to $10 million from IGT 6 and 7 Homeless Health priority area to provide recuperative care services for CalOptima members experiencing homelessness under the County's Whole-Person Care (WPC) Pilot. The WPC Pilot focuses on addressing the needs of Orange County Medi-Cal members experiencing homelessness. The $10 million grant was in addition to $1 million previously allocated for recuperative care for CalOptima members experiencing homelessness and being discharged from a hospital setting.

Back to Agenda

On December 5, 2019 the Board approved $2.5 million of the IGT 6 and 7 funds allocated for recuperative care to be reallocated to housing supportive services for CalOptima Medi-Cal members, excluding those enrolled in the Health Homes Program, which was implemented on January 1, 2020. The Board authorized CalOptima staff to amend CalOptima's current agreement with the County of Orange to effectuate the change in funding support.

On June 30, 2020, Governor Gavin Newsom announced the Homekey Program, the next phase in California's response to support people experiencing homelessness or at risk of homelessness who are impacted by the COVID-19 pandemic. The California Department of Housing and Community Development is providing the Homekey Program grant funding to local public entities, including counties, to purchase, rehabilitate and convert housing, including motels, vacant apartment buildings and other buildings, into interim or permanent housing for qualifying individuals and families impacted by the COVID-19 pandemic. Funding provided by the State can be used towards securing Homekey Program sites or capitalized operating subsidies. In order to receive these funds, Homekey Program applicants are expected to provide a five-year commitment to provide operating funds for their project; these funds can be obtained from any source, including federal, state, local, and private sources.

On July 28, 2020, the Orange County Board of Supervisors adopted a resolution authorizing the County of Orange to submit an application to apply for a Homekey Program grant. On October 9, 2020, California awarded the County of Orange more than $23 million toward two Homekey Program properties, encompassing 132 units, that will be initially focused on interim housing, with the goal to then renovate and covert them into permanaent supportive housing within three years. Funding provided though the State grant will contribute towards acquiring the Homekey Program sites. The County of Orange will need to secure approximately $15.1 million in funding for the operations and administration of services provided at the site. As the funding allocated for housing supportive services has not been utilized yet, the County has requested that the $2.5 million be reallocated for the Homekey Program.

The County is initially expecting to target individuals who are impacted by COVID-19 and/or are transitioning out of Project Roomkey. The State's Project Roomkey was developed to provide hotel and motel rooms for individuals experiencing homelessness in order to prevent the spread of COVID-19. It is estimated that between 80-90% of the Homekey Program participants will be CalOptima members.

Residents at Homekey Program sites will be given the opportunity to work with staff to develop and implement a service plan to address their needs and goals, focusing on placement into permanent housing and connection to available housing resources. The County's goal is that the Homekey Program residents transition to permanent housing quickly (on average, within six months), rather than longer stays for two years or more that sometimes occur with interim housing. This prompt transtion to permanent housing will allow a greater number of Orange County individuals who are homeless, including CalOptima members, to be served at these sites.

In addition to its focus on transition to permanent housing, the individual's service plan will address other needs, such as access to job placement services and enrollment in local, state and federal benefit programs for which the resident may be eligible. If a resident is a CalOptima member with health care

needs, they will be supported in contacting CalOptima, health networks or providers for assistance in health care navigation and access to CalOptima covered benefits.

Discussion

The requested reallocation of $2.5 million of IGT 6 and 7 funds, if approved, will be applied towards enhanced services for CalOptima Medi-Cal members residing in Homekey Program sites. In considering service enhancements that could complement the housing supportive services otherwise expected to be provided to Homekey Program residents, CalOptima turned to the DHCS California Advancing and Innovating Medi-Cal (CalAIM) proposal, which included in lieu of services. In lieu of services are intented to be cost effective, flexible, wrap-around services that a managed care plan can provide as a substitute for, or to avoid, other services that may fill gaps in state plan benefits to address medical or social determminants of health needs. The DHCS initially targeted January 1, 2021 for in lieu of services implementation under CalAIM; however, implementation has been postponed indefinitely as a result of the COVID-19 pandemic.

Day habilitation is identified in the CalAIM proposal as an in lieu of service for individuals experiencing homelessness; day habilitation programs are designed to assist individuals "in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to reside successfully in the person's natural environment." Day habilitation program services include, but are not limited to, training on:

1. The use of public transportation;
2. Personal skills development in conflict resolution;
3. Community participation;
4. Developing and maintaining interpersonal relationships;
5. Daily living skills (cooking, cleaning, shopping, money management); and,
6. Community resource awareness such as police, fire or local services to support independence in the community.

Day habilitation could also include coordination with other programs that provide assistance with, but not limited to:

1. Selecting and moving into a home;
2. Locating and choosing suitable housemates;
3. Locating household furnishings;
4. Settling disputes with landlords;
5. Managing personal financial affairs;
6. Recruiting, screening, hiring, training, supervising and dismissing personal attendants;
7. Dealing with and responding appropriately to governmental agencies and personnel;
8. Asserting civil and statutory rights through self-advocacy;
9. Building and maintaining interpersonal relationships, including a circle of support; and,
10. Assistance with income and benefits advocacy including General Assistance/General Relief and SSI if client is not receiving these services through other programs.

These services are recognized by the DHCS as valuable enhancements to existing Medi-Cal benefits to support individuals to achieve and sustain successful housing. As such, CalOptima staff recommends

Back to Agenda

that the Board reallocate $2.5 million in IGT 6/7 funds that were previously allocated for housing supportive services to a day habilitation program provided at the Homekey Program sites.

As proposed, funds will be provided prior to commencement of services at the Homekey Program sites, such that the County of Orange may utilize these funds for operation and administrative support and other start-up costs, subject to the obligation to provide services to CalOptima Medi-Cal members once a site is up and running. Since the funding will be provided in advance, the agreement will include indemnification, defense and hold harmless provisions to provide that the funds are returned if the project does not go forward, does not ultimately open to provide housing and deliver the day habilitation services for CalOptima members, or the use of the funds for the Homekey Program are challenged and/or recovered by any regulatory agency.

The $2.5 million advance funding for services to CalOptima Medi-Cal beneficiaries will be based on the following reqirements:

- Acquistion of the properties by December 31, 2020;
- The County of Orange must oversee operations, including delivery of the day habilitation services, at the Homekey Program sites;
- The Homekey Program is to provide day habilitation services to CalOptima Medi-Cal members at no additional cost to the members for the greater of three years or until the funding amount is exhausted. Services will be provided to CalOptima Medi-Cal members to be valued at a per member per month equivalent cost (and charged to the CalOptima funding amount pursuant to this proposed arrangement) for similar services currently provided through other county programs;
- Funding will not be used for room and board; and,
- Services provided to CalOptima members do not include services otherwise required to be provided under the Homekey Program or available to the member enrolled in Whole Person Care, Health Homes Program or any successor program providing similar services.

If approved by the Board, CalOptima staff will provide the County of Orange with a commitment letter and will require the County of Orange to complete a grant application. Additionally, subject to the Board's approval, upon completion of the application, CalOptima staff will work with the County of Orange to finalize an agreement, which will also include standard reporting used for community grants demonstrating impact of the Homekey Program on CalOptima members; the reporting will also require information sufficient to account for the value of services hereunder.

Fiscal Impact

The recommended action to authorize reallocation of $2.5 million in IGT 6 and 7 funds from housing supportive services for qualifying CalOptima members to fund day habilitation services for CalOptima Medi-Cal members through the County of Orange Homekey Program has no fiscal impact to CalOptima's Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020. The 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.

Back to Agenda

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal health plan for Orange County, collaborates with our providers, community, and county partners to address the health care needs of CalOptima members and works to improve the availability, access, and quality of health care services. This recommendation continues CalOptima's collaboration with the County of Orange and other community stakeholders to support CalOptima Medi-Cal members experiencing homelessness who are impacted by the COVID-19 pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by This Recommended Board Action
2. CalOptima Board Action dated December 5, 2019, Consider Authorizing Reallocation of Intergovernmental Transfer Funds Previously Allocated for Recuperative Care to Housing Supportive Services; Consider Authorizing Contract(s) and/or Contract Amendment(s) with County of Orange for Implementation

/s/ Richard Sanchez — *10/28/2020*

Authorized Signature — **Date**

Back to Agenda

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip
County of Orange	405 W 5th Street, suite 756	Santa Ana	CA	92701

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

14. Consider Authorizing Reallocation of Intergovernmental Transfer Funds Previously Allocated for Recuperative Care to Housing Supportive Services; Consider Authorizing Contract(s) and/or Contract Amendment(s) with the County of Orange for Implementation

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize reallocation of $2.5 million from the $10 million previously allocated IGT 6 and 7 funds of the total of $11 million allocated for recuperative care and medical respite program to housing supportive services for CalOptima Medi-Cal members;
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to
    a. Amend CalOptima's current agreement with the County of Orange as necessary to allow for reallocation of funds previously allocated to recuperative care for CalOptima members under the County's Whole Person Care (WPC) Pilot Program; and
    b. Enter into a new agreement or amend CalOptima's current agreement with the County of Orange to include housing supportive services for qualifying CalOptima members.

Background

The WPC Pilot is an Orange County-operated pilot program, administered by the Orange County Health Care Agency (OCHCA), that has and continues to develop infrastructure and integrate systems of care to coordinate services for vulnerable Medi-Cal beneficiaries experiencing homelessness. The County of Orange's WPC Pilot application was approved by the Department of Health Care Services (DHCS) in October 2016 and coordinates physical, behavioral health, and social services in a patient-centered approach with the goals of improved and health and well-being through more effective use of resources. The WPC Pilot provides housing supportive services which includes housing navigation and tenancy sustaining services. Additional funding was provided to the WPC Pilot in January 2019 allocating funds specifically to expand existing WPC housing navigation and supportive services for persons living with serious mental illness as well as implement these services for persons who do not have a connection to OCHCA Behavioral Health Services. The WPC Pilot also includes provisions for recuperative care services for up to a maximum of 90 days based on medical need. Recuperative care service is post-acute care for homeless Medi-Cal members who are too ill or frail to recover from a physical illness or injury on the streets, but who do not meet the medical necessity criteria for continued inpatient care and are appropriate for discharge to home.

In May 2017, CalOptima received payment from DHCS for the IGT 6 and 7 transactions and confirmed CalOptima's total share to be approximately $31.1 million. Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. DHCS approved use of IGT 6 and IGT 7 funds to provide enhanced services to CalOptima Medi-Cal members in the following areas: opioid overuse, homeless health care access, children's mental health, adult mental health, childhood obesity, strengthening the

safety net, children's health, older adult health and other areas as identified by a member health needs assessment.

During the August 2, 2018 CalOptima Board of Directors (Board) meeting, the following four focus areas to support community-based organizations through one-time competitive grants where approved: 1) Opioid and Other Substance Overuse; 2) Children's Mental Health; 3) Homeless Health; and, 4) Community needs identified by the CalOptima Member Health Needs Assessment. While community proposals were solicited, the Board made a grant allocation of up to $10 million from IGT 6 and 7 Homeless Health priority area to provide recuperative care services for CalOptima members experiencing homelessness under the County's WPC Pilot in addition to the $1 million earlier allocated for recuperative care for CalOptima members experiencing homelessness and being discharged from a hospital setting. On April 4, 2019 the Board authorized reallocation of $250,000 from the $10 million IGT 6 and 7 recuperative care fund towards a Medical Respite Program for CalOptima Medi-Cal members meeting medical criteria beyond the 90 days available for recuperative care through the WPC Pilot.

On October 28, 2019 DHCS released the initial CalAIM proposal. While this proposal may be further refined prior to implementation, as proposed, it could significantly impact the future Medi-Cal delivery system. One proposed impact would be for Medi-Cal managed care plans, including CalOptima, to provide recuperative care as an In Lieu of Service potentially beginning as soon January 1, 2021. The County of Orange has determined that of the $9.75 million IGT 6 and 7 funding allocated by the CalOptima Board towards recuperative care, at least $2.5 million dollars can be reallocated toward other services without impacting the availability of recuperative care services for CalOptima members.

Discussion

Housing supportive services encompass housing navigation and sustaining services that include client assessments to identify barriers to housing placement and working with both landlords and members to sustain tenancy. Housing supportive services are incorporated into the member's individualized care plan that integrates all physical, behavioral, and social service needs. This member-centric supportive approach assists the individual to integrate into community-based settings which enhances their ability to be a good neighbor to the rest of the community.

The County of Orange provides housing supportive services to those who quality for the WPC Pilot and/or are linked to the County's Behavioral Health Services Program; however, there continue to be individuals who do not quality for services through these programs. In November 2019, OCHCA established a funding pool which is intended to address funding gaps for those needing but not receiving housing supportive services. In order to support these efforts, CalOptima staff recommends reallocating up to $2.5 million in IGT 6 and 7 funds previously allocated for recuperative care for CalOptima members to housing supportive services for CalOptima members. As proposed, these reallocated IGT 6 and 7 funds would be available to reimburse the OCHCA for housing supportive services provided to CalOptima members receiving services through WPC once WPC funding has been exhausted, or for CalOptima members not receiving services through WPC but in need of housing supportive services. CalOptima members enrolled in the Health Homes Program would be excluded as CalOptima is

coordinating with OCHCA to develop a separate agreement for members enrolled in the Health Homes Program.

The County of Orange contracts with vendors to provide housing supportive services. Services contracted vendors are required to provide, when appropriate, include but are not limited to the following:

- Match WPC clients with a housing voucher to appropriate housing resources or provide navigation services to those who do not have housing vouchers;
- Act as a liaison in collaboration with and between the WPC client and landlord;
- Transport or arrange for transportation of WPC clients to potential housing placement opportunities;
- Assist with the housing application process;
- Secure reasonable letters of support as needed;
- Ensure that the WPC client has a security deposit for housing and utilities;
- Ensure that the WPC client becomes a resident after housing placement;
- Arrange for utilities to be turned on;
- Educate WPC clients on housekeeping issues and "good neighbor" issues such as maintenance, community living, and independent living skills;
- Coach WPC clients in order to have successful interactions when meeting with potential property managers, and prepare them for placement; and
- Link WPC clients to peer mentoring and other sustainability services for ongoing support in an effort to further ensure housing sustainability.

Contracted housing supportive services vendors are approved and reimbursed for six months on a per member per month capitated basis. Individuals are reevaluated every six months and services continue until it is determined that the individual no longer requires housing supportive services. As proposed, CalOptima would reimburse the County for housing supportive services provided to qualifying CalOptima members on a per member per month basis.

Fiscal Impact

The recommended actions to authorize reallocation of up to $2.5 million in IGT 6 and 7 funds to housing supportive services for qualifying CalOptima members has no fiscal impact to CalOptima's Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal health plan for Orange County, collaborates with our provider, community, and county partners to address the healthcare needs of CalOptima members and work to improve the availability, access, and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Board Action
2. CalOptima Board Action dated September 7, 2017, Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members
3. CalOptima Board Action dated April 4, 2019, Consider Authorizing Establishment of a Post Whole Person Care Pilot Medical Respite Care Program and Reallocation of Intergovernmental Transfer (IGT) 6/7 Funds Previously Allocated for Recuperative Care in Conjunction with the Orange County Health Care Agency Whole Person Care Pilot Program
4. California Advancing and Innovating Medi-Cal (CalAIM) Executive Summary

/s/ Michael Schrader *11/26/2019*
Authorized Signature **Date**

Attachment to December 5, 2019 Board of Directors Meeting - Agenda Item 14

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip
County of Orange	405 W 5th Street, suite 756	Santa Ana	CA	92701

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for remaining Intergovernmental Transfers (IGT) 2 and 3 recuperative care program funds, in an amount not to exceed $619,300, less any recuperative care funds paid from this pool to hospitals subsequent to July 31, 2017;
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a grant agreement with the Orange County Health Authority (OCHCA) to utilize remaining IGT 2 and 3 Recuperative Care IGT project funds for recuperative care under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members; and
3. Authorize expanded use of the above-referenced CalOptima IGT recuperative care funds to include CalOptima Medi-Cal members referred to the County's recuperative care services program from a broader range of settings, including but not limited to, nursing homes and clinics and from public health nurses, in addition to those referred from the CalOptima contracted hospital setting, subject to amendment of the Department of Health Care Services (DHCS)/County of Orange WPC Pilot Contract ("DHCS/County Contract"), or other written approval from DHCS, reflecting this broader range of settings.

Background

Recuperative Care is a program that provides short-term shelter with medical oversight and case management to homeless persons who are recovering from an acute illness or injury and whose conditions would be exacerbated by living on the street.

At its December 4, 2014, and October 1, 2015, meetings, the CalOptima Board of Directors authorized the expenditure of IGT funds for recuperative care services for Medi-Cal members and amendment of hospital contracts to facilitate referrals to and limited reimbursement for recuperative care services. As a result, CalOptima currently provides reimbursement to contracted hospitals for recuperative care services at a rate of up to $150 per day for up to 15 days per member. The total amount of IGT funds that have been allocated for recuperative care is $1,000,000, with $500,000 from IGT 2 and $500,000 from IGT 3. The program launched in May 2015 and as of July 31, 2017, $380,700 has been spent.

The current CalOptima recuperative care program is available for homeless CalOptima members immediately upon discharge from an inpatient hospitalization or emergency room visit and includes: temporary shelter, medical oversight, case management/social services, meals and supplies, referral to safe housing or shelters upon discharge, and communication and follow-up with referring hospitals.

Back to Agenda Back to Item

On December 30, 2015, DHCS received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015, to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries.

Since the beginning of 2016, OCHCA has collaborated with other county agencies, hospitals, community clinics, community-based organizations, CalOptima and others to design and submit an application to DHCS for WPC in Orange County. The WPC application, approved by DHCS in October 2016, includes provisions for recuperative care. The WPC recuperative care program serves CalOptima members discharged from hospitals (inpatient stays and emergency room visits) and skilled nursing facilities, as well as those directly referred from clinics and OCHCA public health nurses. The DHCS/County Contract, executed in June 2017, states that "if the beneficiary is being admitted into recuperative care directly from a hospital contracted with CalOptima, CalOptima will pay [assuming available funds] for up to 15 days of recuperative care, depending on the medical need. The WPC will pick up payment for recuperative/respite care after CalOptima stops payment up to day 90 of the beneficiary's stay. If the beneficiary is admitted from a non-hospital setting, then the WPC pilot will be responsible for reimbursement for the entire 90-day stay."

Discussion

WPC Pilots must include strategies to increase integration among county agencies, health plans, providers, and other entities within each participating county. Orange County's WPC Pilot is intended to focus on improving outcomes for participants who are homeless and frequently visit local hospital emergency departments. By leveraging existing programs and offering new and enhanced services, the intent of the WPC pilot is to improve access to medical care, social services and housing for participants. Over the course of the program, the WPC Pilot is expected to reduce emergency department and hospital visits, increase visits to primary care/other providers and help participants find permanent housing.

Recuperative care is a critical component of Orange County's WPC Pilot. Depending on member need, as determined on a case-by-case basis, the County's recuperative care program will be responsible for paying for recuperative care services for up to 90 days and is available for homeless Medi-Cal members being discharged from hospitals and skilled nursing facilities. Further, it is available to homeless Medi-Cal members referred by a clinic or public health nurses who might otherwise go to the hospital for care that could be provided in a residential or clinic setting. As indicated above, pursuant to the terms of the DHCS/County Contract, funds provided by CalOptima are only being used for up to the first 15 days of WPC services to Medi-Cal beneficiaries who are being admitted into recuperative care directly from a hospital contracted with CalOptima.

Hospitals currently participating in CalOptima's recuperative care IGT initiative have entered into a Recuperative Care addenda to their existing CalOptima contracts. This allows hospitals to receive reimbursement from CalOptima for up to 15 days of recuperative care at up to $150 per day. As proposed, staff is seeking authority to redirect remaining CalOptima IGT 2 and 3 recuperative care

funding from CalOptima's existing hospital-based program to the County's WPC program. While the WPC permits stays of up to 90 days, the County must "pick up payment for recuperative/respite care after CalOptima stops payment." Consistent with the WPC Pilot, CalOptima would continue to make the IGT funds allocated for recuperative care available up to a maximum of $150/day for up to 15 days per member for qualifying members transitioning to recuperative care from a hospital setting, contingent upon member need and availability of funds, pursuant to the program approved by DHCS. Qualifying recuperative care services resulting from referrals from skilled nursing facilities, clinics, and public health nurses are currently the financial responsibility of the County, and the current DHCS/County Contract indicates that CalOptima is not involved in funding recuperative care services for Members entering recuperative care from these settings.

Staff seeks authority to enter into a grant agreement with the County to redirect the remaining available IGT 2 and 3 recuperative care funds to the County's recuperative care program as discussed above. As a part of the grant agreement, the reimbursement process for recuperative care will be changed. Hospitals will no longer be expected to directly pay for and then seek reimbursement from CalOptima for referrals of homeless CalOptima members to recuperative care. As proposed, OCHCA will invoice CalOptima for up to the first 15 days of recuperative care services referred from a hospital or emergency room (at a rate of up to $150/day).

Once the grant agreement with the County is in place, CalOptima contracted hospitals will no longer be eligible to obtain reimbursement for recuperative care services from CalOptima for the duration of the WPC Pilot. However, until such time, to the extent that funds remain available, CalOptima will continue to reimburse hospitals that bill CalOptima directly for reimbursement for qualifying members. CalOptima and OCHCA staff will coordinate and maintain processes to ensure no duplication of payments.

As indicated, CalOptima funding for the program is limited to those funds remaining from those allocated to the existing CalOptima recuperative care program operated through its contracted hospitals, and invoice payments will be made only until those funds are exhausted.

Potential Broadening of Eligibility Categories. While the current DHCS/County Contract specifies that CalOptima funds are to be used exclusively for homeless members discharged from CalOptima-contracted hospitals to a recuperative care setting, the County is proposing to allow for the use of CalOptima funds for services to members admitted to recuperative care from other settings including skilled nursing facilities and clinics and by public health nurses, in addition to members referred from contracted hospitals. This proposed approach could increase the flexibility in administration of the program, and broaden the range of members covered by the allocated funding. Staff is requesting, subject to amendment of the DHCS/County Contract, that the Board authorize broader use of the remaining IGT 2 and 3 funds allocated for recuperative care, consistent with an amendment of the DHCS/County Contract, or other written approval from DHCS, allowing such use of CalOptima funds. As proposed, the maximum $150 daily payment rate and 15 day maximum stay currently applicable to referrals from contracted hospitals would also apply to referrals from such additional sources.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Of the $1.0 million in IGT funds approved by the Board for recuperative care, remains available as of July 31, 2017. Payments for recuperative care services provided under this staff recommendation are contingent upon availability of existing IGT funds. Any additional funding for recuperative care would require future Board consideration and approval. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working "Better. Together." CalOptima, as the community health plan for Orange County, is committed to working with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services for Medi-Cal members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 4, 2014, Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation
2. Board Action dated October 1, 2015, Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

1. Authorize expenditures of up to $500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised 12/4/14

Background

At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

Discussion

Staff requests authority by the Board of Directors to allocate up to $500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

Back to Agenda Back to Item

CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the $500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

Fiscal Impact

A total of up to $500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of $150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

Rationale for Recommendation

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

Concurrence

Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of $3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of $4,880,000 in IGT 3 funds to support this purpose, and authorize hospital contract amendments as necessary to implement the proposed modifications to the recuperative care program.

Rev. 10/1/15

Background / Discussion

To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing $26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional $5.5 million in project funds. Collectively, the four IGTs represent $31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	$12.4 million
IGT 2	$8.7 million
IGT 3	$4.9 million
IGT 4	*$5.5 million**
Total	$31.5 million

*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

IGT 2 Updated Expenditure Plan

At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of $3,875,000 in IGT 2 funds to support the following projects:

- $2,400,000 previously approved for the 'Expansion of IGT 1 Initiatives' will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.

- $100,000 previously approved for the 'Expansion of IGT 1 Initiatives' will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.

- $875,000 previously approved for 'Children's Health/Safety Net Services' will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.

- $500,000 previously approved for 'Wraparound Services' will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.

- Staff also request a modification to the Board's December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from $50,000 up to $100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from $50,000 to $100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics' FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

IGT 3 Expenditure Plan

For the $4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- $4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima's Model of Care.

  $500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board's previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

These recuperative care services would be made available subject to required regulator approval(s), if any.

- $165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

Fiscal Impact
The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of $4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

Rationale for Recommendation
Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

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

9/25/2015 — **Date**

CalOptima
A Public Agency
Better. Together.

IGT Progress Report and Proposal

Board of Directors Meeting
October 1, 2015

Lindsey Angelats
Dir, Strategic Development

IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	$12.4 M	100%
IGT 2	13-14	$8.7 M	55%
IGT 3	14-15	$4.8 M	0%
IGT 4	15-16*	(Est. $5.5 M)*	NA
Total Funds Received or Anticipated		$31.4 M	

* Transaction has received state and federal approval but funds have not yet been received

Considerations for IGT Outstanding Funds

- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
  - 1115 Waiver and Whole Person Care
  - Behavioral Health Integration
  - Health Homes
  - Capitation Pilot for Federally Qualified Health Centers

- **Value in supporting providers serving more vulnerable members with greater needs:** *(examples)*
  - Investment in ICTs for providers serving Seniors and Persons with Disabilities
  - Continuation/expansion of Personal Care Coordinators

IGT Investment Parameters and Requirements



- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries

- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

Recommended Use of IGT 2 Funds ($3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
Continuation of IGT 1 Initiatives	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	$2.4M	**Coordinated Care Initiative**	Providers and members receive timely support
Children's Health/Safety Net Services	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	$875K	**Alternative Payment Pilot**	FQHCs launch critical services that can be sustained through higher PPS rates
Wraparound Services	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	$500K	**Autism Benefits in Managed Care**	Earlier identification and treatment for the 1 in 68 children with autism
Continuation of IGT 1 Initiatives	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents ~~23%~~ between 2-3% admin costs)	$100K	**Intergovernmental Transfers**	Faster launch of IGT funded projects to support members and physicians

Recommended Use of IGT 3 Funds ($4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	**Adult Mental Health**	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	Support for improved and integrated care for vulnerable members
Integrated Care	**Support Primary Care Access**	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	$165K	Faster launch of IGT funded projects to support members and physicians

Recommended Next Steps

- **Timing**
  - November: Development of project plans and launch
- **Accountability**
  - Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016
- **Engagement**
  - Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression
- **Maximization/Leverage**
  - ➢ In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

Board of Directors Meeting
October 1, 2015

Intergovernmental Transfer (IGT) Funds Progress Report

Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
New Case Management System	To enhance management and coordination of care for vulnerable members	$2M	03/06/14	2 years	75%
Personal Care Coordinators for OneCare members	To help OneCare members navigate healthcare services and to facilitate timely access to care	$3.8M	04/03/14	3 years	50%
OneCare Connect Personal Care Coordinators	To help OneCare Connect members navigate health services and to facilitate timely access to care	$3.6M	04/02/15	1 year	25%
Strategies to Reduce Readmission	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	$1.05 M	03/06/14	2 years	25%
Complex Case Management Consulting	Staffing and data support for case management system	$350K	03/06/14	2 years	50%
Telemedicine	Expand access to specialty care	$1.1M	03/07/13	2 years	25%
Program for High Risk Children	CalOptima pediatric obesity and pediatric asthma planning and evaluation	$500K	03/06/14	3 years	25%

Back to Agenda Back to Item

IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
Continuation of the CalOptima Regional Extension Center	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	$1M	04/03/14	3 years	25%
Enhancing the Safety Net	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	$200K	10/02/14	2 years	50%
Enhancing the Safety Net	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	$225K	12/04/14	2 years	25%
Recuperative Care	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	12/04/14	1 year	25%
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
School-Based Vision	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	$500K	09/04/14	2 years	25%
School-Based Dental	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	$400K	09/04/14	2 years	25%
Provider Network Management Solution	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	$500K	03/06/14	1 year	25%
Security Audit Remediation	To increase protection of CalOptima member data	$200K	03/06/14	1 year	85%

Back to Agenda Back to Item

Attachment to December 5, 2019 Board of Directors Meeting -- Agenda Item 14

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

6. Consider Authorizing Establishment of a Post Whole Person Care Pilot Medical Respite Care Program and Reallocation of Intergovernmental Transfer (IGT) 6/7 Funds Previously Allocated for Recuperative Care in Conjunction with the Orange County Health Care Agency Whole Person Care Pilot Program

Contacts

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize the establishment of a Medical Respite Program for CalOptima members meeting clinical criteria who have exhausted available recuperative care days under the Orange County Health Care Agency (OCHCA) Whole Person Care Pilot (WPC) program; staff to return to the Board for approval of implementing policies, and obtaining state approval, as appropriate;
2. Authorize reallocation of $250,000 to fund the Medical Respite Program from the $10 million previously allocated IGT 6/7 funds for recuperative care in support of the OCHCA WPC program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's agreement with the County of Orange to allow for reallocation of funds away from the WPC program for medically justified medical respite services for qualifying homeless CalOptima members who have exhausted available recuperative care days under the WPC program.

Background

The WPC is an Orange County-operated pilot program that has and continues to develop infrastructure and integrate systems of care to coordinate services for vulnerable Medi-Cal beneficiaries experiencing homelessness. Orange County's WPC application was approved by the Department of Health Care Services (DHCS) in October 2016 which includes provisions for recuperative care services for up to a maximum of 90 days. Recuperative care service is post-acute care for homeless Medi-Cal members who are too ill or frail to recover from a physical illness or injury on the streets, but who do not meet the medical necessity criteria for continued inpatient care and are appropriate for discharge to home.

In May 2017, CalOptima received payment from DHCS for the IGT 6 and 7 transactions and confirmed CalOptima's total share to be approximately $31.1 million. Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. DHCS approved use of IGT 6 and IGT 7 funds to support programs addressing the following areas: Community health investments which may include programs addressing opioid overuse, homeless health care access, children's mental health, adult mental health, childhood obesity, strengthening the safety net, children's health, older adult health and other areas as identified by a member health needs assessment. At the August 2, 2018 Board of Directors meeting, the following four focus areas to support community-based organizations through one-time competitive grants where approved: 1) Opioid and Other Substance Overuse; 2) Children's Mental Health; 3) Homeless Health; and, 4) Community needs identified by the CalOptima Member Health Needs Assessment. A grant allocation of up to $10 million was approved from IGT 6 and 7 Homeless Health priority area to provide recuperative care services for homeless CalOptima members under the WPC

pilot. The funds are currently designated for funding 50 percent of medically justified recuperative care bed days up to a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available. The CalOptima Board of Directors also approved an amendment of the agreement with the County of Orange to include indemnity language and allowing for use of the allocated funds for recuperative care services under the County's WPC Pilot program for qualifying homeless CalOptima members.

Discussion

Since 2016, the OCHCA has collaborated with CalOptima and other community-based organizations, community clinics, hospitals, and county agencies to design and implement the WPC Pilot program. The recuperative care element of the WPC pilot is a critical component of the program. During calendar year 2018, the WPC recuperative care program provided services to 487 unique CalOptima members experiencing homelessness. Between August and December 2018, the average length of stay for these individuals was 34 days, at a cost of $705,250.

As part of evaluating the progress of the WPC pilot program, it has been identified though discussions with OCHCA that some CalOptima members have circumstances that are expected to require a stay beyond the 90 days that are available under the scope of the WPC pilot. These members, such as those who have been certified for hospice care or need intravenous (IV) chemotherapy but do not qualify for transition to skilled nursing care, may benefit from medical respite care beyond the 90 days of recuperative care.

To address this concern, CalOptima staff, with the support of OCHCA WPC staff, and consistent with the approved IGT 6/7 funding categories, is proposing to develop a Medical Respite Program for CalOptima members who need extended medical care beyond the 90 days as provided under the current scope of the WPC Pilot to achieve and maintain medical stability. Staff is in the process of developing policies related to the proposed medical respite program, the purpose of which is to provide short-term residential care to allow individuals with unstable living situations the opportunity to rest in a safe and clean environment while accessing medical care and other supportive services. In addition to providing post-acute care and clinical oversight, medical respite care seeks to improve transitional care for the population and to aid in ending the cycle of homelessness while also gaining stability with case management relationships and programs. As appropriate, staff will seek state approval of this new Medical Respite Program, which is intended to support homeless CalOptima members as they recover and attain medical stability, or in the case of members in hospice, to receive services in a stable environment care. The additional time beyond the days available through the County's WPC program is intended to reduce inappropriate and/or avoidable utilization of hospital Emergency Departments, inpatient admissions and re-admissions.

CalOptima Members nearing the end of their available recuperative days in the WCP program will be evaluated on a case-by-case basis and will need approval by County WPC staff, County Medical Safety Net (MSN) program nurses and CalOptima to be eligible for the Medical Respite Program. Regular reviews and updates will be conducted by the MSN program nurses to ensure that 1) Members do not stay longer than appropriate and 2) Members receive appropriate care to achieve and maintain medical

stability and steps to move to a skilled nursing facility (SNF), if appropriate. It is anticipated that approximately two members per month will meet criteria to receive medical respite care. CalOptima will monitor utilization and member outcomes.

In addition, staff is seeking authority to reallocate $250,000 out of the $10 million the Board allocated to OCHCA WPC program for recuperative care to fund the Medical Respite Program. In other words, no new funding is being proposed. Instead, the recommendation for authority is to redirect dollars previously committed for recuperative care for homeless CalOptima members in coordination with the County's WPC program. Staff is also seeking authority to provide the OCHCA with reimbursement for the full cost of the Medical Respite Program stay at $120 per day, for all bed days beyond the WPC Pilot recuperative care program, not to exceed the requested reallocation amount of $250,000. The OCHCA supports the recommended actions and plans to continue to invoice CalOptima for members in the Medical Respite Program via a similar process such as the already established invoicing process for recuperative care. The funds will be available through the end of the WPC Pilot or until the funds are exhausted, whichever comes first.

Fiscal Impact
The recommended actions to authorize the creation of a Medical Respite Program for CalOptima members and to authorize a reallocation of $250,000 from the $10 million IGT allocation to Orange County Health Care Agency (OCHCA) for recuperative care services, previously approved by the Board on August 2, 2018, has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. CalOptima Board Action dated September 7, 2017, Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members
2. CalOptima Board Action dated August 2, 2018, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

Back to Agenda Back to Item

CalOptima Board Action Agenda Referral

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for remaining Intergovernmental Transfers (IGT) 2 and 3 recuperative care program funds, in an amount not to exceed $619,300, less any recuperative care funds paid from this pool to hospitals subsequent to July 31, 2017;
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a grant agreement with the Orange County Health Authority (OCHCA) to utilize remaining IGT 2 and 3 Recuperative Care IGT project funds for recuperative care under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members; and
3. Authorize expanded use of the above-referenced CalOptima IGT recuperative care funds to include CalOptima Medi-Cal members referred to the County's recuperative care services program from a broader range of settings, including but not limited to, nursing homes and clinics and from public health nurses, in addition to those referred from the CalOptima contracted hospital setting, subject to amendment of the Department of Health Care Services (DHCS)/County of Orange WPC Pilot Contract ("DHCS/County Contract"), or other written approval from DHCS, reflecting this broader range of settings.

Background

Recuperative Care is a program that provides short-term shelter with medical oversight and case management to homeless persons who are recovering from an acute illness or injury and whose conditions would be exacerbated by living on the street.

At its December 4, 2014, and October 1, 2015, meetings, the CalOptima Board of Directors authorized the expenditure of IGT funds for recuperative care services for Medi-Cal members and amendment of hospital contracts to facilitate referrals to and limited reimbursement for recuperative care services. As a result, CalOptima currently provides reimbursement to contracted hospitals for recuperative care services at a rate of up to $150 per day for up to 15 days per member. The total amount of IGT funds that have been allocated for recuperative care is $1,000,000, with $500,000 from IGT 2 and $500,000 from IGT 3. The program launched in May 2015 and as of July 31, 2017, $380,700 has been spent.

The current CalOptima recuperative care program is available for homeless CalOptima members immediately upon discharge from an inpatient hospitalization or emergency room visit and includes: temporary shelter, medical oversight, case management/social services, meals and supplies, referral to safe housing or shelters upon discharge, and communication and follow-up with referring hospitals.

Back to Agenda Back to Item

On December 30, 2015, DHCS received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015, to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries.

Since the beginning of 2016, OCHCA has collaborated with other county agencies, hospitals, community clinics, community-based organizations, CalOptima and others to design and submit an application to DHCS for WPC in Orange County. The WPC application, approved by DHCS in October 2016, includes provisions for recuperative care. The WPC recuperative care program serves CalOptima members discharged from hospitals (inpatient stays and emergency room visits) and skilled nursing facilities, as well as those directly referred from clinics and OCHCA public health nurses. The DHCS/County Contract, executed in June 2017, states that "if the beneficiary is being admitted into recuperative care directly from a hospital contracted with CalOptima, CalOptima will pay [assuming available funds] for up to 15 days of recuperative care, depending on the medical need. The WPC will pick up payment for recuperative/respite care after CalOptima stops payment up to day 90 of the beneficiary's stay. If the beneficiary is admitted from a non-hospital setting, then the WPC pilot will be responsible for reimbursement for the entire 90-day stay."

Discussion

WPC Pilots must include strategies to increase integration among county agencies, health plans, providers, and other entities within each participating county. Orange County's WPC Pilot is intended to focus on improving outcomes for participants who are homeless and frequently visit local hospital emergency departments. By leveraging existing programs and offering new and enhanced services, the intent of the WPC pilot is to improve access to medical care, social services and housing for participants. Over the course of the program, the WPC Pilot is expected to reduce emergency department and hospital visits, increase visits to primary care/other providers and help participants find permanent housing.

Recuperative care is a critical component of Orange County's WPC Pilot. Depending on member need, as determined on a case-by-case basis, the County's recuperative care program will be responsible for paying for recuperative care services for up to 90 days and is available for homeless Medi-Cal members being discharged from hospitals and skilled nursing facilities. Further, it is available to homeless Medi-Cal members referred by a clinic or public health nurses who might otherwise go to the hospital for care that could be provided in a residential or clinic setting. As indicated above, pursuant to the terms of the DHCS/County Contract, funds provided by CalOptima are only being used for up to the first 15 days of WPC services to Medi-Cal beneficiaries who are being admitted into recuperative care directly from a hospital contracted with CalOptima.

Hospitals currently participating in CalOptima's recuperative care IGT initiative have entered into a Recuperative Care addenda to their existing CalOptima contracts. This allows hospitals to receive reimbursement from CalOptima for up to 15 days of recuperative care at up to $150 per day. As proposed, staff is seeking authority to redirect remaining CalOptima IGT 2 and 3 recuperative care

funding from CalOptima's existing hospital-based program to the County's WPC program. While the WPC permits stays of up to 90 days, the County must "pick up payment for recuperative/respite care after CalOptima stops payment." Consistent with the WPC Pilot, CalOptima would continue to make the IGT funds allocated for recuperative care available up to a maximum of $150/day for up to 15 days per member for qualifying members transitioning to recuperative care from a hospital setting, contingent upon member need and availability of funds, pursuant to the program approved by DHCS. Qualifying recuperative care services resulting from referrals from skilled nursing facilities, clinics, and public health nurses are currently the financial responsibility of the County, and the current DHCS/County Contract indicates that CalOptima is not involved in funding recuperative care services for Members entering recuperative care from these settings.

Staff seeks authority to enter into a grant agreement with the County to redirect the remaining available IGT 2 and 3 recuperative care funds to the County's recuperative care program as discussed above. As a part of the grant agreement, the reimbursement process for recuperative care will be changed. Hospitals will no longer be expected to directly pay for and then seek reimbursement from CalOptima for referrals of homeless CalOptima members to recuperative care. As proposed, OCHCA will invoice CalOptima for up to the first 15 days of recuperative care services referred from a hospital or emergency room (at a rate of up to $150/day).

Once the grant agreement with the County is in place, CalOptima contracted hospitals will no longer be eligible to obtain reimbursement for recuperative care services from CalOptima for the duration of the WPC Pilot. However, until such time, to the extent that funds remain available, CalOptima will continue to reimburse hospitals that bill CalOptima directly for reimbursement for qualifying members. CalOptima and OCHCA staff will coordinate and maintain processes to ensure no duplication of payments.

As indicated, CalOptima funding for the program is limited to those funds remaining from those allocated to the existing CalOptima recuperative care program operated through its contracted hospitals, and invoice payments will be made only until those funds are exhausted.

Potential Broadening of Eligibility Categories. While the current DHCS/County Contract specifies that CalOptima funds are to be used exclusively for homeless members discharged from CalOptima-contracted hospitals to a recuperative care setting, the County is proposing to allow for the use of CalOptima funds for services to members admitted to recuperative care from other settings including skilled nursing facilities and clinics and by public health nurses, in addition to members referred from contracted hospitals. This proposed approach could increase the flexibility in administration of the program, and broaden the range of members covered by the allocated funding. Staff is requesting, subject to amendment of the DHCS/County Contract, that the Board authorize broader use of the remaining IGT 2 and 3 funds allocated for recuperative care, consistent with an amendment of the DHCS/County Contract, or other written approval from DHCS, allowing such use of CalOptima funds. As proposed, the maximum $150 daily payment rate and 15 day maximum stay currently applicable to referrals from contracted hospitals would also apply to referrals from such additional sources.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Of the $1.0 million in IGT funds approved by the Board for recuperative care, remains available as of July 31, 2017. Payments for recuperative care services provided under this staff recommendation are contingent upon availability of existing IGT funds. Any additional funding for recuperative care would require future Board consideration and approval. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working "Better. Together." CalOptima, as the community health plan for Orange County, is committed to working with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services for Medi-Cal members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 4, 2014, Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation
2. Board Action dated October 1, 2015, Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

1. Authorize expenditures of up to $500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised 12/4/14

Background

At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

Discussion

Staff requests authority by the Board of Directors to allocate up to $500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

Back to Agenda Back to Item

CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the $500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

Fiscal Impact

A total of up to $500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of $150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

Rationale for Recommendation

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

Concurrence

Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of $3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of $4,880,000 in IGT 3 funds to support this purpose, and authorize hospital contract amendments as necessary to implement the proposed modifications to the recuperative care program.

Rev. 10/1/15

Background / Discussion

To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing $26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional $5.5 million in project funds. Collectively, the four IGTs represent $31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	$12.4 million
IGT 2	$8.7 million
IGT 3	$4.9 million
IGT 4	*$5.5 million**
Total	$31.5 million

*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

IGT 2 Updated Expenditure Plan

At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of $3,875,000 in IGT 2 funds to support the following projects:

- $2,400,000 previously approved for the 'Expansion of IGT 1 Initiatives' will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.

- $100,000 previously approved for the 'Expansion of IGT 1 Initiatives' will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.

- $875,000 previously approved for 'Children's Health/Safety Net Services' will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.

- $500,000 previously approved for 'Wraparound Services' will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.

- Staff also request a modification to the Board's December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from $50,000 up to $100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from $50,000 to $100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics' FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

IGT 3 Expenditure Plan

For the $4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- $4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima's Model of Care.

  $500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board's previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

These recuperative care services would be made available subject to required regulator approval(s), if any.

- $165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

Fiscal Impact
The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of $4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

Rationale for Recommendation
Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

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

9/25/2015 — **Date**

CalOptima
A Public Agency
Better. Together.

IGT Progress Report and Proposal

Board of Directors Meeting
October 1, 2015

Lindsey Angelats
Dir, Strategic Development

IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	$12.4 M	100%
IGT 2	13-14	$8.7 M	55%
IGT 3	14-15	$4.8 M	0%
IGT 4	15-16*	(Est. $5.5 M)*	NA
Total Funds Received or Anticipated		$31.4 M	

* Transaction has received state and federal approval but funds have not yet been received

Considerations for IGT Outstanding Funds

- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
  - 1115 Waiver and Whole Person Care
  - Behavioral Health Integration
  - Health Homes
  - Capitation Pilot for Federally Qualified Health Centers

- **Value in supporting providers serving more vulnerable members with greater needs:** *(examples)*
  - Investment in ICTs for providers serving Seniors and Persons with Disabilities
  - Continuation/expansion of Personal Care Coordinators

IGT Investment Parameters and Requirements



- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries

- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

Recommended Use of IGT 2 Funds ($3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
Continuation of IGT 1 Initiatives	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	$2.4M	**Coordinated Care Initiative**	Providers and members receive timely support
Children's Health/Safety Net Services	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	$875K	**Alternative Payment Pilot**	FQHCs launch critical services that can be sustained through higher PPS rates
Wraparound Services	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	$500K	**Autism Benefits in Managed Care**	Earlier identification and treatment for the 1 in 68 children with autism
Continuation of IGT 1 Initiatives	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents ~~23%~~ between 2-3% admin costs)	$100K	**Intergovernmental Transfers**	Faster launch of IGT funded projects to support members and physicians

Recommended Use of IGT 3 Funds ($4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	**Adult Mental Health**	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	Support for improved and integrated care for vulnerable members
Integrated Care	**Support Primary Care Access**	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	$165K	Faster launch of IGT funded projects to support members and physicians

Recommended Next Steps

- **Timing**
  - November: Development of project plans and launch
- **Accountability**
  - Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016
- **Engagement**
  - Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression
- **Maximization/Leverage**
  - ➢ In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

Board of Directors Meeting
October 1, 2015

Intergovernmental Transfer (IGT) Funds Progress Report

Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
New Case Management System	To enhance management and coordination of care for vulnerable members	$2M	03/06/14	2 years	75%
Personal Care Coordinators for OneCare members	To help OneCare members navigate healthcare services and to facilitate timely access to care	$3.8M	04/03/14	3 years	50%
OneCare Connect Personal Care Coordinators	To help OneCare Connect members navigate health services and to facilitate timely access to care	$3.6M	04/02/15	1 year	25%
Strategies to Reduce Readmission	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	$1.05 M	03/06/14	2 years	25%
Complex Case Management Consulting	Staffing and data support for case management system	$350K	03/06/14	2 years	50%
Telemedicine	Expand access to specialty care	$1.1M	03/07/13	2 years	25%
Program for High Risk Children	CalOptima pediatric obesity and pediatric asthma planning and evaluation	$500K	03/06/14	3 years	25%

Back to Agenda Back to Item

IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
Continuation of the CalOptima Regional Extension Center	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	$1M	04/03/14	3 years	25%
Enhancing the Safety Net	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	$200K	10/02/14	2 years	50%
Enhancing the Safety Net	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	$225K	12/04/14	2 years	25%
Recuperative Care	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	12/04/14	1 year	25%
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
School-Based Vision	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	$500K	09/04/14	2 years	25%
School-Based Dental	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	$400K	09/04/14	2 years	25%
Provider Network Management Solution	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	$500K	03/06/14	1 year	25%
Security Audit Remediation	To increase protection of CalOptima member data	$200K	03/06/14	1 year	85%

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
17. Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

Contact
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions
1. Approve an additional grant allocation of up to $10 million to the Orange County Health Care Agency (OCHCA) from the Department of Health Care Services-approved and Board-approved Intergovernmental Transfer 6 and 7 Homeless Health priority area;
2. Replace the current cap of $150 on the daily rate and the 15-day stay maximum paid out of CalOptima funds with a 50/50 cost split arrangement with the County for stays of up to 90 days for homeless CalOptima members referred for medically justified recuperative care services under OCHCA's Whole Person Care Pilot program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the grant agreement with the County of Orange to include indemnity language and allow for use of the above allocated funds for recuperative care services under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members.

Background
Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus, funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants at the recommendation of the IGT Ad Hoc committee to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Needs Assessment

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the board approved priority areas. The RFI/LOIs helped staff determine funding allocation amounts for the board-approved priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

Back to Agenda Back to Item

Priority Area	# of LOIs
Children's Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	**117**

Staff examined the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

In May 2017, CalOptima received final payment from DHCS for the IGT 6 and 7 transaction and confirmed CalOptima's total share to be approximately $31.1 million.

Discussion

The IGT Ad Hoc committee consisting of Supervisor Do and Directors Nguyen and Schoeffel met on February 17 and reconvened on April 17 to further discuss the results of the RFI/LOI responses specifically in the Homeless Health priority area and to review the staff-recommended IGT 6 and 7 expenditure plan with suggested allocation of funds per priority area.

Since receiving the RFI/LOIs, the County of Orange over the past several months has been engaged in addressing the homelessness in Orange County. Numerous public agencies and non-profit organizations, including CalOptima, have been working diligently to address this challenging matter. A lot has been accomplished, yet much more needs to be addressed.

Before making recommendation to the Board on the release of the limited grant dollars, the Ad Hoc committee met to carefully review the staff-recommended IGT 6 and 7 expenditure plan while also considering the pressing homeless issue.

In response to this on-going and challenging environment, and through the recommendation of the Ad Hoc committee, staff is recommending an allocation of up to $10 million to the OCHCA from IGT 6 and 7 to address the health needs of CalOptima's members in the priority area of Homeless Health

This will result in a remaining balance of approximately $21.1 million, which the Ad Hoc will consider separately and return to the Board with further recommendations.

In addition, staff is seeking authority to amend the grant agreement with the County to direct the allocation of up to $10 million of funds to provide recuperative care services for homeless CalOptima members under the recuperative care/WPC Pilot. The current agreement with the County allows CalOptima to pay for a maximum of $150 per day up to 15 days of recuperative care per member, with the County responsible for any costs. Staff is proposing to remove the cap on the daily rate and allow the $10 million to be used for funding 50 percent of all medically justified recuperative care days up to

a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available, and subject to negotiation of an amendment to include indemnification by the County in the event that such use of CalOptima IGT funds is subsequently challenged or disallowed.

The WPC Pilot, a county-run program is intended to focus on improving outcomes for participants, developing infrastructure and integrating systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries. The current WPC Pilot budget and services are as follows:

		Add'l	
	Total WPC	**County Funds**	**CalOptima**
WPC Connect - electronic data sharing system	$ 2,421,250	$ -	$ -
Hospitals - Homeless Navigators	$ 5,164,000	$ -	$ -
Community Clinics - Homeless Navigators	$ 7,495,000	$ -	$ -
Community Referral Network - social services referral system	$ 1,000,000	$ -	$ -
Recuperative Care Beds	$ 4,277,615	$ 3,483,627	$ 522,100
MSN Nurse - Review & Approval of Recup. Care	$ 628,360	$ -	$ -
211 OC - training and housing coordination	$ 526,600	$ -	$ -
CalOptima - Homeless Personal Care Coordinators & Data Reporting	$ 809,200	$ -	$ -
Housing Navigators	$ 1,824,102	$ -	$ -
Housing Peer Mentors	$ 1,600,000	$ -	$ -
County Behavioral Health Services Outreach Staff	$ 1,668,013	$ -	$ -
Shelters	$ 2,446,580	$ -	$ -
County Admin	$ 1,206,140	$ -	$ -
TOTAL	$31,066,860	$ 3,483,627	$ 522,100

Since the 2016, the OCHCA collaborated with other community-based organizations, community clinics, hospitals, county agencies and CalOptima and others to design the program and has met with stakeholders on a weekly basis. The recuperative care element of the WPC pilot is a critical component of the program. During the first program year, the WPC recuperative care program provided vital services to homeless CalOptima members. CalOptima members in the WPC pilot program are recuperating from various conditions such as cancer, back surgery, and medication assistance and care for frail elderly members. The WPC pilot program has three recuperative care providers providing services, Mom's Retreat, Destiny La Palma Royale and Illumination Foundation.

From July 1, 2017 through June 30, 2018, the WPC pilot program provided the following recuperative care services and linkages for members:

- 445 Homeless CalOptima members admitted into recuperative care for a total of 16,508 bed days
- 22% Homeless CalOptima members served by Illumination Foundation placed into Permanent Supportive Housing
- 4 Homeless CalOptima members in recuperative care approved for Long-Term Care services
- 6 Homeless CalOptima members in recuperative care approved for Assisted Living Waiver services

- Total cost for recuperative care services over the fiscal year: $2,946,700
    - Average length of stay: 37 days
    - Average cost per member: $6,623

The OCHCA experienced a shortfall in the budgeted funds for the WPC/Recuperative Care Program in Year 1 as more individuals were identified to be eligible for the program than projected. The Whole Person Care pilot budget is approximately $31 million, with $8.4 million allocated to provide recuperative care. As the WPC pilot moves into the new fiscal year, the program continues to experience a shortfall. To address the budget shortfall, the number of admissions into the recuperative care program was restricted; however, projected need is projected to increase over the next three years to approximately 2,368 homeless individuals, or 790 per year. The program will need approximately $18.6M over the next three years to meet the increased need for recuperative care services. The County's remaining WPC budget for recuperative care services over this period is approximately $5.3 million.

Individuals who are recovering safely through the program are connected to medical care, including primary care medical homes and medical specialists. In addition, members may receive behavioral health therapy and/or substance use disorder counseling services. Clients from the WPC pilot program are seven times more likely to use the Emergency Room (ER) and nine times more likely to be hospitalized than general Medi-Cal Members.

The WPC recuperative care program serves and is available for homeless CalOptima members when medically indicated, for members who are discharged from hospitals and skilled nursing facilities, as well as those referred from clinics, and OCHCA public health nurses.

Fiscal Impact
The recommended action to approve the allocation of $10 million from IGT 6 and IGT 7 to the OCHCA has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

Back to Agenda Back to Item

California Advancing and Innovating Medi-Cal (CalAIM)
Executive Summary

The Department of Health Care Services (DHCS) has developed a framework for the upcoming waiver renewals that encompasses broader delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, insufficient behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population. This proposal recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal that target social determinants of health and reduce health disparities and inequities. Furthermore, the broader system, program, and payment reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services and puts the focus on improving outcomes for all Californians. Attaining such goals will have significant impact on an individual's health and quality of life, and through iterative system transformation, ultimately reduce the per-capita cost over time. DHCS intends to work with the Administration, Legislature and our other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are initial proposals whose implementation will ultimately depend on whether funding is available.

Background and Overview

Medi-Cal has significantly expanded and changed over the last ten years, most predominantly because of changes brought by the Affordable Care Act and various federal regulations as well as state-level statutory and policy changes. During this time, the DHCS has also undertaken many initiatives and embarked on innovative demonstration projects to improve the beneficiary experience. In particular, DHCS has increased the number of beneficiaries receiving the majority of their physical health care through Medi-Cal managed care plans. These plans are able to offer more complete care coordination and care management than is possible through a fee-for-service system. They can also provide a broader array of services aimed at stabilizing and supporting the lives of Medi-Cal beneficiaries.

Depending on the needs of the beneficiary, some may need to access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental, developmental, In Home Supportive Services, etc.). As one would expect, need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. Therefore, in order to meet the behavioral, developmental, physical, and oral health needs of all members in an integrated, patient centered, whole person fashion, DHCS is seeking to integrate our delivery systems and

align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.

To achieve such outcome, CalAIM proposals offer the solutions to ensure the stability of Medi-Cal program and allows the critical successes of waiver demonstrations such as Whole Person Care, the Coordinated Care Initiative, public hospital system delivery transformation, and the coordination and delivery of quality care to continue and be expanded to all Medi-Cal enrollees. CalAIM seeks to build upon past successes and improve the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time through a comprehensive array of health and social services spanning all levels of intensity of care, from birth to end of life. To do this, we must change the expectations for our managed care and behavioral health systems. Holding our delivery system partners accountable for a set of programmatic and administrative expectations is no longer enough. We must provide a wider array of services and supports for complex, high need patients whose health outcomes are in part driven by unmet social needs and make system changes necessary to close the gap in transitions between delivery systems, opportunities for appropriate step-down care and mitigate social determinants of health, all hindering the ability to improve health outcomes and morbidity.

Guiding Principles

In 2018, the Care Coordination Advisory Committee developed a core set of guiding principles. For the purposes of CalAIM DHCS built off and refined those principles to guide the work we intended to pursue.

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, and oral health needs of all members.
- Work to align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health and reduce disparities or inequities.
- Drive system transformation that focuses on value and outcomes.
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve plan and provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

Key Goals

To achieve such principles, CalAIM has three primary goals:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and

- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

The reforms of CalAIM are comprehensive and critical to the success of the delivery system transformation necessary to improve the quality of life for Medi-Cal members as well as long-term cost savings/avoidance that will not be possible to achieve absent these initiatives. Furthermore, these reforms are interdependent and build off one another; without one, the others are not either possible or powerful. Below is an overview of the various proposals and recommendations that make up CalAIM.

Identify and Manage Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health

California continues to strengthen integration within the State's health care delivery system aimed at achieving better care, better health and reduced expenditures in Medi-Cal programs. In line with these objectives, DHCS is proposing reforms that would better identify and manage member risk and need for beneficiaries who may be challenged with medical and behavioral conditions, access to care issues, as well as chronic illnesses and disabilities, and require multidisciplinary care to regain health and function.

To achieve such goals, DHCS proposes the following recommendations that focus on a whole-person care approach that addresses the needs of our beneficiaries across the board – looking at physical and behavioral as well as social determinants of health, with the overarching goals of improving quality of life and reducing the overall costs for the Medi-Cal population.

- Require plans to submit local population health mangement plans.
- Implement new statewide enhanced care management benefit.
- Implement in lieu of services (e.g. housing navigation/supporting services, recuperative care, respite, sobering center, etc.).
- Implement incentive payments to drive plans and providers to invest in the necessary infrastructure, build appropriate enhanced care management and in lieu of services capacity statewide.
- Evaluate participation in Institutions for Mental Disease Serious Mental Illness/Serious Emotional Disturbance Section 1115 Expenditure Waiver.
- Require screening and enrollment for Medi-Cal prior to release from county jail.
- Pilot full integration of physical health, behavioral health, and oral health under one contracted entity in a county or region.
- Develop a long-term plan for improving health outcomes and delivery of health care for foster care children and youth.

Population Health Management

Medi-Cal managed care plans shall develop and maintain a patient-centered population health strategy, which is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes. Each managed care plan shall include, at a minimum, a description of how it will:

- Keep all members healthy by focusing on preventive and wellness services;

- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate social determinants of health and reduce health disparities or inequities.

Enhanced Care Management

DHCS proposes to establish a new, statewide enhanced care management benefit. An enhanced care management benefit would provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-need Medi-Cal beneficiaries. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals. The proposed benefit builds on the current Health Homes Program and Whole Person Care pilots, and transitions those pilots to this new statewide benefit to provide a broader platform to build on positive outcomes from those programs.

Target populations include, but are not limited to:

- High utilizers with frequent hospital or emergency room visits/admissions;
- Individuals at risk for institutionalization with Serious Mental Illness, children with Serious Emotional Disturbance or Substance Use Disorder with co-occurring chronic health conditions;
- Individuals at risk for institutionalization, eligible for long-term care;
- Nursing facility residents who want to transition to the community;
- Children or youth with complex physical, behavioral, developmental and oral health needs (i.e. California Children Services, foster care, youth with Clinical High Risk syndrome or first episode of psychosis);
- Individuals transitioning from incarceration; and
- Individuals experiencing chronic homelessness or at risk of becoming homeless.

In Lieu of Services & Incentive Payments

In order to build upon and transition the excellent work done under Whole Person Care, DHCS is proposing to implement in lieu of services, which are flexible wrap-around services that a managed care plan will integrate into its population health strategy. These services are provided as a substitute, or to avoid, other services such as a hospital or skilled nursing facility admission or a discharge delay. In lieu of services would be integrated with Case or Care Management for members at high levels of risk and may fill gaps in state plan benefits to address medical or social determinants of health needs. Examples of in lieu of services include but are not limited to: housing transition and sustaining services, recuperative care, respite, home and community based wrap around services for beneficiaries to transition or reside safely in their home or community, and sobering centers.

The use of in lieu of services are voluntary, but the combination of enhanced care management and in lieu of services allows for a number of integration opportunities, including an incentive for building an integrated managed long-term services and supports (MLTSS) managed care program by 2026 and building the necessary clinically-linked housing continuum for our homeless population. In order to be equipped with the required MLTSS and housing infrastructure, the State must use its ability to provide our Medi-Cal managed care plans with financial incentive payments established to drive plans and providers to invest in the necessary

delivery and systems infrastructure, build appropriate care management and in lieu of services capacity, and achieve improvements in quality performance and measurement reporting that can inform future policy decisions.

Institutions for Mental Disease (IMD) Expenditure Waiver

Currently, federal Medicaid funding cannot be used for institutional services provided to individuals with serious mental illness or severe emotional disturbance (known as the IMD exclusion). However, the federal government has developed an opportunity for states to seek the ability to receive federal funding for institutional services provided to these populations. Through extensive stakeholder engagement, DHCS will assess state and county interest in pursuing the IMD expenditure waiver, as well as readiness of our systems to achieve the required goals and outcomes. Such a proposal must be budget neutral and would allow counties to "opt-in." The main elements of any proposed waiver would include:

- Ensuring quality of care in psychiatric hospitals and residential settings, including required audits;
- Improving care coordination and transitions to community based care;
- Increasing access to a full continuum of care including crisis stabilization and other clinically enriched forms of housing in the community with robust support services; and
- Earlier identification and engagement in treatment including through increased integration.

In pursuing this waiver opportunity, counties that "opt in" should be prepared to build out a robust continuum so individuals who begin at a higher level of institutional care can be stepped down to a less restrictive, community-based, residential setting.

Mandatory Medi-Cal Application Process upon Release from Jail

Justice involved individuals often receive both medical and behavioral health services while incarcerated. Upon release from jail, proper coordination is needed to ensure the medical and behavioral health needs of an individual continue to be met, and additionally ensure critical non-clinical needs are met like housing, transportation and overall integration back into the community. Studies have shown, such coordination activities reduce unnecessary emergency room and inpatient stays, as well as improve treatment and medication adherence upon release from jail. In an effort to ensure all county inmates receive timely access to Medi-Cal services upon release from incarceration, DHCS proposes that California mandate the county inmate pre-release Medi-Cal application process by January 2022. Additionally, DHCS is proposing to mandate all counties implement warm-handoffs from county jail release to county behavioral health departments when the inmate was receiving behavioral health services while incarcerated to allow for continuation of behavioral health treatment in the community.

Full Integration Plans

DHCS would like to test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity. Due to the complexity of the policy considerations around this concept, DHCS will need to conduct extensive stakeholder engagement around eligibility criteria for entities, administrative requirements across delivery systems, provider network requirements, quality and reporting requirements, as well as complex financial

considerations due to realignment and Prop 30 implications. Given the complexity of this proposal, DHCS assumes the selected plans would not go live until 2024, as DHCS and our managed care plans and county partners work together to develop the most appropriate delivery systems for this purpose.

Develop a Long-Term Plan for Foster Care

In 2020, DHCS would like to form a group of stakeholders to weigh in on a long-term plan and strategy for improving health outcomes and the delivery of fully-integrated health care services for foster care children and youth. Based on the recommendations from such workgroup, DHCS, California Department of Social Services, and other sister departments would work to implement such changes based on timelines developed in the stakeholder process.

Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

Medi-Cal provides services to some of California's most vulnerable and medically complex beneficiaries, but many of the services are different depending on the county one lives in. DHCS is proposing to standardize and reduce complexity by implementing administrative and financial efficiencies across the state and delivery systems to provide more predictability and reduce county-to-county differences. These reforms stretch across managed care, behavioral health, dental and other county based services.
To achieve such goals, DHCS proposes the following recommendations.

Managed Care

- Standardize managed care enrollment statewide
- Standardize managed care benefits statewide
- Transition to statewide managed long term services and supports
- Require Medi-Cal managed care plans be National Committee for Quality Assurance accredited
- Implement annual Medi-Cal health plan open enrollment
- Implement regional rates for Medi-Cal managed care plans

Behavioral Health

- Behavioral health payment reform
- Revisions to behavioral health inpatient and outpatient medical necessity criteria for children and adults
- Administrative behavioral health integration statewide
- Regional contracting
- Substance use disorder managed care program renewal and policy improvements

Dental

- New benefit: Caries Risk Assessment Bundle and Silver Diamine Fluoride for young children
- Pay for Performance for adult and children preventive services and continuity of care through a Dental Home

County Based Services

- Enhance oversight and monitoring of Medi-Cal Eligibility
- Enhance oversight and monitoring of California Children's Services and the Child Health and Disability Prevention program
- Improving beneficiary contract and demographic information

Managed Care

Managed Care Enrollment

By January 2021, DHCS proposes requiring all non-dual eligible Medi-Cal beneficiaries and by January 2023 requiring all dual beneficiaries, statewide to be enrolled mandatorily in a managed care plan, with the exception of those for whom managed care enrollment does not make sense due to limited scope of benefits or limited time enrolled. This will eliminate variation of managed care enrollment practices that currently vary by aid code, population, or geographical location.

Standardize Managed Care Benefit

By January 2021, DHCS proposes to standardize managed care plans benefits, so that all Medi-Cal managed care plans provide the same benefit package. Some of the most significant changes are the carving-in of institutional long-term care and major organ transplants into managed care statewide and, per Executive Order, the carving out of pharmacy.

Transition to Statewide Managed Long-Term Services and Supports

In order to achieve a more standardized approach to comprehensive care coordination for all populations, DHCS is proposing to discontinue the Cal MediConnect pilot program at the end of calendar year 2022. DHCS proposes to transition from the pilot approach of the Coordinated Care Initiative to standardized mandatory enrollment of dual eligibles into a Medi-Cal managed care plan for Medi-Cal benefits and integration of long-term care into managed care for all Medi-Cal populations statewide. This will be done in two phases:

January 2021: The Coordinated Care Initiative proceeds as today, however Multipurpose Senior Services Programs will be carved out and all institutional long-term care services will be carved into managed care for all populations enrolled in plans around the state. DHCS will also implement the voluntary in lieu of services benefit at this time.

January 2023: Full transition of the Coordinated Care Initiative to mandatory managed care enrollment of dual eligibles into managed care in all counties/plan models. In addition, require Medi-Cal managed care plans to operate Medicare Dual-Special Needs Plans, in order to offer dual eligible members the ability to have coordinated managed care plans for both their Medi-Cal and Medicare benefits.

The purpose of these transitions and phases is to target a long-term goal of implementing managed long term services and supports (MLTSS) statewide in Medi-Cal managed care beginning in 2026 by providing enough time and incentive to develop the needed infrastructure. This will allow beneficiaries to receive needed MLTSS and home and community based services statewide through their managed care plan, instead of a variety of 1915(c) waivers that currently have capped enrollment and are not statewide.

NCQA Accreditation of Medi-Cal Managed Care Plans

In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their subcontractors (delegated entities) to be National Committee for Quality Assurance (NCQA) accredited by 2025. DHCS would use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain State and federal Medicaid requirements.

Annual Medi-Cal Health Plan Open Enrollment

Effective for plan enrollment as of January 1, 2022, DHCS proposes to implement an Annual Health Plan Open Enrollment process for all managed care plan enrollees. Enrollees would generally only be allowed to change their managed care plan during the Annual Health Plan Open Enrollment period which is consistent with health care industry practice. The Annual Health Plan Open Enrollment period would first begin in November 2021. However in recognition of the concerns previously raised by stakeholders, DHCS has developed this proposal to include a consumer-friendly exemption process that will allow members who have a real need to change plans mid-year to do so in a streamlined way. Enrollment into Medi-Cal coverage would still be allowed throughout the year. This proposal provides the stability required to do effective care and case management of the plan members, while still allowing a simplified process to allow a plan change when it is needed.

Regional Rates

DHCS proposes to shift the development of Medi-Cal managed care plan rates from a county-based model to a regional rate model, this also coincides with a shift of the rating period from the state fiscal year to the calendar year beginning in 2020. The proposal to move to regional rates has two main benefits. The first benefit is a decreased number of distinct actuarial rating cells that are required and submitted to CMS for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS with goal of allowing DHCS to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates will allow cost averaging across all plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for the averaging rather than just the experience of plans within the county. This change is fundamental to the ability of DHCS to implement the other changes proposed in CalAIM.

Behavioral Health

Behavioral Health Payment Reform

The state, in partnership with counties, must take serious steps forward to invest in and improve access to mental health and substance use disorder services for Medi-Cal beneficiaries. Behavioral health transformation is a critical priority for the Governor, the California Health and Human Services Agency, and for DHCS, and we recognize that the full needs of the Medi-Cal population are not being met, particularly with respect to improving services and access for children and other vulnerable populations. In order to achieve true reform, DHCS believes that an important first step is undergoing behavioral health payment reform, where DHCS will

transition counties from a cost-based reimbursement methodology to a structure more consistent with incentivizing outcomes and quality over volume and cost. Such a shift is being designed in conjunction with our county partners and will enable counties to participate in broader delivery system transformation and engage in value-based payment arrangements with their health plan partners in order to support better coordination and integration between physical and behavioral health. This shift will be done thoughtfully with a key focus on ensuring no disruption of services or financial challenges for our county partners.

Behavioral health payment reform is an essential step to other opportunities for the counties around behavioral health integration, regional contracting and delivery system investments needed to further build a high quality continuum of care for mental health and substance use disorder services in the community.

Revisions to Behavioral Health Medical Necessity

The medical necessity criteria for specialty mental health services is outdated, lacks clarity, and should be re-evaluated. This issue creates confusion, misinterpretation, and could affect beneficiary access to services as well as result in disallowances of claims for specialty mental health and substance use disorder services. DHCS is proposing to modify the medical necessity criteria in order to align with state/federal requirements and more clearly delineate and standardize the benefit statewide.

Administrative Behavioral Health Integration Statewide

Research indicates that approximately 50% of individuals who have a serious mental illness have a co-occurring substance use disorder and that those individuals benefit from integrated treatment. The State provides Medi-Cal covered substance use disorder and specialty mental health services through two separate county-operated delivery systems, which makes it difficult for counties to provide integrated treatment to individuals who have co-occurring disorders. For example, counties participating in mental health and substance use disorder managed care are subject to two separate annual quality assessments, two separate post payment chart audits, and two separate reimbursement and cost reporting methods. In order to comply with these separate processes, counties providing integrated treatment to a Medi-Cal beneficiary must document the substance use disorder service separately from the specialty mental health service. The purpose of this proposal is to make necessary state and county changes that would provide substance use disorder and specialty mental health services through one delivery system.

Behavioral Health Regional Contracting

DHCS recognizes that some counties have resource limitations often due simply to their size and the number of beneficiaries residing in their county. Therefore, DHCS encourages counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to operate such services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources

should consider opportunities for regional partnership. Furthermore, DHCS is interested in discussing how counties not currently seeking substance use disorder managed care participation may be more interested in doing so through a regional approach and/or how services provided under substance use disorder fee-for-service might also be provided through a regional approach. DHCS is committed to working with counties to offer technical assistance and support to help develop regional contracts and establish innovative partnerships.

Substance Use Disorder Managed Care Program Renewal and Policy Improvements

DHCS proposes to incorporate the Drug Medi-Cal Organized Delivery System (also known as substance use disorder managed care) into a comprehensive Section 1915(b) waiver that would include the Medi-Cal managed care plans, mental health managed care plans, and substance use disorder managed care plans. The expenditure authority for residential treatment provided in an Institution for Mental Disease will continue to be authorized through Section 1115 waiver authority. DHCS also intends to provide counties with another opportunity to opt-in to participate in the substance use disorder managed care program in hopes of promoting statewideness. Finally, DHCS is exploring opportunities to improve the substance use disorder managed care program based on experience from the first several years of implementation. Accordingly, DHCS proposes clarifying or changing policies to support the goal of improved beneficiary care and administrative efficiency.

Dental

The Department has set an initial goal to achieve at least a 60 percent dental utilization rate for eligible Medi-Cal children. In order to progress towards achieving that goal, and based on our lessons learned from the Dental Transformation Initiative, DHCS proposes the following reforms for Medi-Cal dental be made statewide:

- Add new Dental Benefits based on the outcomes and successes from the Dental Transformation Initiative that will provide better care and align with national dental care standards. The proposed new benefits include a Caries Risk Assessment Bundle for young children and Silver Diamine Fluoride for young children and specified high risk and institutional populations; and
- Continue and expand Pay for Performance Initiatives initiated under the Dental Transformation Initiative that reward increasing the use of preventive services and establishing/maintaining continuity of care through a Dental Home. These expanded initiatives would be available statewide for children and adult enrollees.

County Partners

Enhancing County Oversight and Monitoring: Eligibility

This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office as identified in a recent audit. This proposal will also ensure that DHCS is compliant with federal and State requirements. These enhancement will be done in direct collaboration with our county partners.

Enhancing County Oversight and Monitoring: CCS and CHDP

There are several programs – including California Children's Services, the Medical Therapy Program, and the Child Health and Disability Prevention program – that provide services to over 750,000 child beneficiaries. The State delegates certain responsibilities for these high-risk children to California's 58 counties. The State needs to enhance the oversight of counties to ensure they comply with legislation, regulations, and State issued guidance. Enhancing monitoring and oversight will eliminate disparities in care and reduce vulnerabilities to the State, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

Improving Beneficiary Contact and Demographic Information

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which contact and demographic information can be updated by other entities and the means to accomplish this while maintaining compliance with all applicable State and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported updated data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services programs, Medi-Cal beneficiaries, managed care plans, and the provider community.

For more detailed descriptions of the CalAIM proposals please refer to the full CalAIM document located on CalAIM page of the DHCS website.

Advancing Key Priorities

These reforms are interdependent and build off one another; without one, the others are neither possible or powerful.

As DHCS has assessed the changes proposed under CalAIM, it has become apparent that these proposals are critically dependent upon each other. These reforms are fundamental to achieve the overall goals of improving the system and outcomes for Medi-Cal beneficiaries as well as providing long-term fiscal and programmatic sustainability to the Medi-Cal program and delivery system. In developing these recommendations, DHCS has recognized that individual proposals are significantly less likely to be achievable and successful if other key proposals are not pursued. For example, absent the proposed financing changes with respect to both the regional rate setting for Medi-Cal managed care and the structural changes to Medi-Cal behavioral health financing, the ability of our partnered plan and county entities to institute the changes focused on value based and integrated delivery of care are significantly harder and potentially impossible to achieve. These fundamental financing changes themselves would not be possible without the elimination of differences across counties with respect to the delivery systems through which Medi-Cal benefits are delivered. Therefore, carving out prescription drugs from managed care (Medi-Cal Rx) and the other carve-in/carve-outs detailed in the Medi-Cal managed care proposals are necessary and serve as the foundation for DHCS to institute the concepts around not only regional rate setting, but also nearly every other proposal contained within CalAIM (such as enhanced care management, in lieu of services, and incentive payments, as well as the

possibility of future full integration pilots). The Medi-Cal program has evolved over the multiple decades since inception and has relied upon ever-increasing system and fiscal complexity in order to operate and serve the Californians who rely upon it. CalAIM offers DHCS and the entire State of California an opportunity to take a step back to better assess what Medi-Cal beneficiaries need and alter the delivery systems accordingly, while at the same time working to be the most effective with respect to the funding utilized to most efficiently operate the program.

Furthermore, CalAIM aligns with and advances several key priorities of the Administration. At its core, CalAIM recognizes the impact of Medi-Cal on the lives of its beneficiaries well beyond just accessing health services in traditional delivery settings. CalAIM establishes a foundation where investments and programs within Medicaid can easily integrate, complement and catalyze the Administration's plan to impact the State's homelessness crisis, support reforms of our justice systems for youth and adults who have significant health issues, build a platform for vastly more integrated systems of care and move toward a level of standardization and streamlined administration required as we explore single payer principles through the Healthy California for All Commission. Furthermore, CalAIM will advance a number of existing Medi-Cal efforts such as Whole Person Care and the Health Homes Program, the prescription drug Executive Order, improving screenings for kids, proliferating the use of value-based payments across our system, including in behavioral health and long-term care. CalAIM will also support the ongoing need to increase oversight and monitoring of all county-based services including specialty mental health and substance use disorder services, Medi-Cal eligibility, and other key children's programs currently administered by our county partners.

Below is an overview of the impact CalAIM could have on certain populations, if enacted and funded as proposed:

Health for All: In addition to focusing on preventive and wellness services, CalAIM will identify patients with high and emerging risk/need and improve the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time, through a comprehensive array of health and social services spanning all levels of intensity of care, from birth and early childhood to end of life.

High Utilizers (top 5%): It is well documented that the highest utilizers represent a majority of the costs in Medi-Cal. CalAIM proposes enhanced care management and in lieu of services benefits (such as housing transitions, respite and sobering centers) that address the clinical and non-clinical needs of high-cost Medi-Cal beneficiaries, through a collaborative and interdisciplinary whole person care approach to providing intensive and comprehensive care management services to improve health and mitigate social determinants of health.

Behavioral Health: CalAIM's behavioral health proposals would initiate a fundamental shift in how Californians (adults and children) will access specialty mental health and substance use disorder services. It aligns the financing structure of behavioral health with that of physical health, which provides financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care. Similarly, the reforms in CalAIM simplify administration of, eligibility for, and access to integrated behavioral health care.

Vulnerable Children: CalAIM would provide access to enhanced care management for medically complex children to ensure they get their physical, behavioral, developmental and oral health needs met. It aims to identify innovative solutions for providing low-barrier,

comprehensive care for children and youth in foster care and furthers the efforts already underway to improve preventive services for children including identifying the complex impacts of trauma, toxic stress and adverse childhood experiences by, among other things, a reexamination of the existing behavioral health medical necessity definition.

Homelessness and Housing: The addition of in lieu of services would build capacity to clinically linked housing continuum via in lieu of services for our homeless population, including housing transitions/navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions and day habilitation programs.

Justice Involved: The Medi-Cal pre-release application mandate, enhanced care management and in lieu of services would provide the opportunity to better coordinate medical, behavioral health and non-clinical social services for justice-involved individuals prior to and upon release from county jails. These efforts will support scaling of diversion and reentry efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities, further aligning with other state hospital efforts to better support care for felons incompetent to stand trial and other forensic state-responsible populations.

Aging Population: In lieu of services would allow the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide by 2026. MLTSS will provide appropriate services and infrastructure for home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and should be a critical component on the State's Master Plan on Aging.

From Medi-Cal 2020 to CalAIM

Through CalAIM, DHCS is undertaking a more targeted approach to consolidating its Medi-Cal benefit package in an attempt to achieve better alignment across the system. While Section 1115 waiver authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating budget neutrality for waivers. CMS in recent guidance has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools. In addition, given that California has significant learnings from our past 1115 Waivers, DHCS believes a primary shift to the use of other authorities is now appropriate to allow us to expand beyond limited pilots to more statewide initiatives. These factors, combined with new federal managed care regulations, has encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for innovation in the Medi-Cal program.

The proposal outlines all elements of the Medi-Cal 2020 waiver and how they will be incorporated in to CalAIM. DHCS does not believe California is losing any critical funding or abilities to improve and advance the delivery systems and ultimately improve the beneficiary experience and outcomes under this federal authority approach. In fact, the proposed shift will allow programs or pilots that have traditionally lived outside the core managed care system, where nearly 85%

of all Medi-Cal beneficiaries receive care, to be brought into the main fold of managed care. We look forward to working in close partnership with our federal CMS colleagues and local partners to ensure that the Medi-Cal program continues to change in ways that ultimately further the goals of improved health and outcomes, as well as cost effectiveness, of the Medi-Cal/Medicaid program.

CalAIM Stakeholder Engagement

DHCS' intention in the release of these proposals is to garner important input from the many key stakeholders and partners that help us to improve upon these concepts and align them with the expertise and experience of our partners. As previously outlined, DHCS will be undertaking a significant stakeholder engagement effort that begins with the release of this document and continues through the CalAIM workgroups scheduled for November through February, the Stakeholder Advisory Committee (SAC) and Behavioral Health SAC meetings, Medi-Cal Health Advisory Panel (MCHAP) and other convenings. We recognize that CalAIM contains many significant proposals and changes to the Medi-Cal program, aimed at ultimately improving the beneficiary experience and outcomes. However, these represent DHCS' initial proposals and thinking and we look forward to working to refine and modify these proposals relying on the expertise of our stakeholder partners through this engagement process. DHCS plans to finalize all proposals for submission to CMS in the May to July period of 2020 based on the input we will receive from our partners through this process, but also dependent on the funding availability through the state budget process

Conclusion

CalAIM is an ambitious but necessary proposal to positively impact our beneficiaries' quality of life by improving the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time through a comprehensive set of health and social services spanning all levels of intensity of care, from birth to end of life.

CalAIM:

- Keeps all beneficiaries healthy by focusing on preventive and wellness services, while also identifying and assessing member risk and need on an ongoing basis, during transitions in care, and across delivery systems, through effective care coordination.

- Creates a fundamental shift in how Californians (adults and children) will access mental health and substance use disorder services including administration of, eligibility for, and access to integrated behavioral health care.

- Provides access to enhanced care management for medically complex children and adults to ensure they get their physical, behavioral, developmental and oral health needs met.

- Builds capacity in clinically linked housing continuum via in lieu of services for our homeless population, including housing transitions/navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions and day habilitation programs.

- Provides the opportunity to better coordinate clinical and non-clinical services for justice-involved individuals prior to and upon release from jail.

- Allows the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide. MLTSS will provide appropriate services and infrastructure for home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and will be a critical component on the State's Master Plan on Aging.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Quality Assurance Committee

Report Item

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

Contacts

David Ramirez, M.D., Chief Medical Officer, (714) 347-3261
Betsy Ha, Executive Director, Quality and Population Health Management, (714) 246-8574
Kelly Rex-Kimmet, Director, Quality Analytics, (657) 235-6937

Recommended Action

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the contract with Inovalon to update product terminology consistent with the vendor's move to a cloud-based platform and include an additional one year extension option through October 31, 2025 exercisable at CalOptima's sole discretion.

Background

HEDIS is a required method of reporting "healthcare effectiveness" using established and standard measurement criteria developed by the National Committee for Quality Assurance (NCQA). HEDIS scores determine the Medicare Stars Rating, and HEDIS reporting is required by the Centers for Medicare & Medicaid Services for health plans (including CalOptima) that offer any Medicare products, for the California Department of Health Care Services (DHCS) regulatory quality reporting, and for NCQA accreditation.

HEDIS reporting is complex and requires the support of a NCQA certified HEDIS reporting vendor to adequately comply with regulations and to ensure accurate and timely reporting as well as auditability. CalOptima has contracted with Inovalon as the vendor of choice for HEDIS reporting.

In 2006, a request for proposal (RFP) was issued to identify and select a HEDIS reporting vendor. Inovalon (named MedAssurant at the time) was selected and a contract effective November 1, 2006 was entered into for a five-year term ending on October 31, 2011. This was initially approved by the CalOptima Board of Directors as part of the Fiscal Year (FY) 2006-07 budget.

On June 2, 2011, the Board approved an extension of the agreement with Inovalon (then named Catalyst) through October 31, 2016. Subsequently, on August 4, 2016, the Board approved an extension of the Inovalon agreement through October 31, 2019.

In June 2018, the Board approved an extension of the Inovalon agreement which would extend the contract until October 31, 2022, with two optional one-year renewal terms through October 31, 2024. However, the current contract does not reflect the renewal terms, and therefore staff is seeking an extension through October 31, 2025.

Back to Agenda

In the summer of 2014, staff evaluated the HEDIS reporting marketplace through a Request for Information (RFI) process and solicited input from HEDIS reporting vendors. Nine vendors responded to CalOptima's RFI. However, five of the responding vendors were either not NCQA certified or only partially certified and were disqualified. The remaining four were evaluated based on cost and functionality. Based on this process, staff supported the continuation of the Inovalon agreement based on three primary factors remaining true: lowest cost, full functionality, and existing relationship.

Discussion

HEDIS reporting has become somewhat of a commodity among the vendors in the marketplace. The differentiators are cost and relationship. CalOptima has a favorable pricing structure with Inovalon and a strong relationship that has enabled consistently positive HEDIS reporting and audit results which have contributed to CalOptima's continuous five year rating from NCQA as California's top rated Medicaid plan. Inovalon has migrated to a new cloud-based platform which is HITRUST certified. The new platform has been carefully evaluated by staff, including IT security. Due to the fact that a change to the hosting platform required a new amendment due to material changes to the contract's product terminology, staff recommends that the Board authorize an amendment to address these cost neutral changes, and also authorize the addition of an additional one year extension option (exercisable at CalOptima's sole discretion) to provide CalOptima with the option of capitalizing on favorable pricing assuming the vendor continues to perform to CalOptima's satisfaction. The current contract runs through October 31, 2022, and staff will return to the Board with recommendations on the extension options based on the vendor's performance during and following the transition to the cloud-based platform.

Fiscal Impact

The CalOptima FY 2020-21 Operating Budget includes maintenance and support fees for the Inovalon contract for the period of July 1, 2020, through June 30, 2021. Management plans to include expenses related to this initiative in future operating budgets.

Rationale for Recommendation

The recommendation will maintain continuity of HEDIS reporting and maintenance of a successful vendor relationship.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachments

1. Previous Board Action Dated June 7, 2018, "Consider Authorizing a Contract Extension with the Healthcare Effectiveness Data and Information Set (HEDIS) Reporting Vendor, Inovalon, for Software Licensing, Maintenance and Related Services"
2. Previous Board Action Dated June 2, 2011, "Authorize Extension of the Contract for Certified HEDIS Software"
3. Previous Board Action Dated June 6, 2006, "Approve the CalOptima Fiscal Year 2006-07 Capital Budget"
4. Entities Covered by this Recommended Board Action

/s/ Richard Sanchez *10/28/2020*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

48. Consider Authorizing a Contract Extension with the Healthcare Effectiveness Data and Information Set (HEDIS) Reporting Vendor, Inovalon, for Software Licensing, Maintenance, and Related Services

Contact

Len Rosignoli, Chief Information Officer, (714) 246-8400
Richard Bock, M.D., Deputy Chief Medical Officer, (714) 246-8400

Recommended Actions

1. Authorize the CEO, with the assistance of legal counsel, to extend the contract with Inovalon, CalOptima's National Committee for Quality Assurance (NCQA)-certified Healthcare Effectiveness Data and Information Set (HEDIS) Reporting vendor, through October 31, 2022, with two optional one-year renewal terms through October 31, 2023, and October 31, 2024; and
2. Authorize payment of software licensing, maintenance, and services fees through the term of the contract.

Background

HEDIS reporting is a regulatory requirement of the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS), as well as a required component of the NCQA accreditation submission. HEDIS reporting uses established and standard measurement criteria in the monitoring of the effectiveness of healthcare delivery and management, or essentially the quality of the healthcare delivery system. HEDIS scores are a component of the NCQA overall health plan rating determination.

HEDIS reporting is complex and requires the support of a NCQA-certified HEDIS reporting vendor to adequately comply with regulations and to ensure accurate and timely reporting as well as auditability. CalOptima contracted with Inovalon as the vendor of choice for HEDIS reporting. Inovalon provides software to monitor HEDIS measures, software for reporting on the measures, customized measures and associated reporting, associated software maintenance, and a fixed amount of services and support for CalOptima-specific HEDIS measures and the related reporting.

In 2006, a request for proposal (RFP) was issued to find and select a HEDIS reporting vendor. Inovalon (named MedAssurant at the time) was selected and a contract effective November 1, 2006, was executed for a five-year term, ending on October 31, 2011. This was approved by the CalOptima Board of Directors as part of the Capital budget for Fiscal Year (FY) 2006-07.

On June 2, 2011, the Board approved an extension of the Inovalon agreement (then named Catalyst) through October 31, 2016. In addition, that agreement (still current) allowed for the option to extend for three (3) additional one-year terms, the latest ending October 31, 2019.

In the summer of 2014, staff conducted a Request For Information (RFI) process to evaluate the HEDIS

reporting marketplace and solicit input from HEDIS reporting vendors. Nine vendors responded to CalOptima's RFI. At the time, five of the responding vendors were either not NCQA certified or only partially certified and were disqualified. The remaining four were evaluated based on cost and functionality. Based on this process, staff supported the continuation of the Inovalon agreement based on three primary factors: cost, full functionality, and existing relationship.

Based on the RFI results from 2014, and the extension language within the Inovalon agreement, in August of 2016, the Board authorized exercising the remaining contract extension options. Currently, the contract is set to expire October 31, 2019.

Discussion

As HEDIS reporting is complex, any change in vendor would require significant planning for implementation – and would require an overlap of services for several months, with both the existing and new vendor. It is because of this long lead time that staff is approaching the Board with this recommended action more than one year before the current contract expires.

On a consistent basis, staff monitors research and performance of the HEDIS marketplace. Overall, staff's assessment is that little has changed in the past four years. Of the existing certified vendors, many are not suitable for CalOptima for a variety of reasons. Some have less than the required full functionality, some have little or no experience with Medi-Cal, some refuse to provide pricing unless selected as a finalist, and some utilize offshore resources. Some of the vendors that submitted a proposal four years ago are no longer certified, sometimes based on the challenges in maintaining currency with the increasing complexity of CMS and DHCS quality measure requirements. However, Inovalon has continued to provide full functionality and many improvements over the years.

This extension and amendment will include an increase in cost, as anticipated. The increase is less than staff expected, and in line with the current market. The proposal received from the incumbent vendor quotes pricing at an increase of approximately 16%.

The partial duplication of cost, the potential risk to the CalOptima NCQA rating and ranking, and the operational disruption of changing vendors for such a mission-critical business function supports the staff recommendation to continue with Inovalon. As a result, staff is recommending Board approval for a contract extension, and an exception to our bidding process for this business/system solution.

Fiscal Impact

The proposed FY 2018-19 Operating Budget pending Board approval includes annual fees for the existing HEDIS reporting vendor for the period of July 1, 2018, through June 30, 2019. Management will include expenses related to the recommended contract extension for the period of November 1, 2019, through October 31, 2022, in future operating budgets.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 4, 2016, Consider Extension of Contract with National Committee for Quality Assurance (NCQA)-Certified Vendor Inovalon which Provides Healthcare Effectiveness Data and Information Set (HEDIS) Reporting Support.
    a. Board Action dated June 2, 2011, Authorize Extension of the Contract for Certified HEDIS Software.

/s/ Michael Schrader — *5/30/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

32. Consider Extension of Contract with National Committee for Quality Assurance (NCQA)-Certified Vendor Inovalon which Provides Healthcare Effectiveness Data and Information Set (HEDIS) Reporting Support

Contact

Len Rosignoli, Chief Information Officer, (714) 246-8400
Caryn Ireland, Executive Director, Quality, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to:

1. Extend the Inovalon contract through October 31, 2019; and
2. Authorize payment of maintenance and support fees under the Inovalon contract through October 31, 2019.

Background

For Medicare-related products, HEDIS is a required method of reporting "healthcare effectiveness" using established and standard measurement criteria in a variety of areas. HEDIS helps to determine the Medicare Stars Rating, and HEDIS reporting is required for health plans (including CalOptima) that offer any Medicare products, for the California Department of Health Care Services (DHCS) regulatory quality reporting, and for NCQA accreditation.

Medicare uses a Star Rating System to measure how well Medicare Advantage and prescription drug (Part D) plans perform. Ratings range from one to five stars, with five being highest. Medicare scores how well plans performed in over 90 measurement areas within categories including:

- Staying Healthy – includes screenings, tests, vaccines, and other check-ups that help members stay healthy.
- Managing chronic (long-term) conditions – includes how often members in this category get certain necessary tests and treatments that help them manage their condition.
- Member experience with health plan and drug coverage – includes ratings of member satisfaction with the health plan.
- Member complaints and changes in the health plan's performance – includes how often Medicare found problems with the plan and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.
- Health Plan customer service – includes how well the plan handles member appeals.
- Drug safety and accuracy of drug pricing – includes how accurate the plan's pricing information is and how often members with certain medical conditions are prescribed drugs in a way that is safer and clinically recommended for their condition.

HEDIS reporting is complex and requires the support of a NCQA certified HEDIS reporting vendor to adequately comply with regulations and to ensure accurate and timely reporting as well as auditability.

Back to Agenda Back to Item

CalOptima contracted with Inovalon as the vendor of choice for HEDIS reporting.

In 2006, a request for proposal (RFP) was issued to find and select a HEDIS reporting vendor. Inovalon (named MedAssurant at the time) was selected and a contract effective November 1, 2006, was executed for a five-year term, ending on October 31, 2011. This was approved by the CalOptima Board of Directors as part of the Capital budget for Fiscal Year (FY) 2006-07.

On June 2, 2011, the Board approved an extension of the Inovalon agreement (then named Catalyst) through October 31, 2016. The current agreement allows for the option to extend for three (3) additional one-year terms, the latest ending October 31, 2019.

In the summer of 2014, staff evaluated the HEDIS reporting marketplace through a request for information (RFI) process to solicit input from HEDIS reporting vendors. Nine vendors responded to CalOptima's RFI. Five of the responding vendors were either not NCQA certified or only partially certified and were disqualified. The remaining four were evaluated based on cost and functionality. Based on this process, staff supported the continuation of the Inovalon agreement based on three primary factors remaining true: lowest cost, full functionality, and existing relationship.

Discussion
As a result of the recent market evaluation completed in 2014, and very limited shift in this industry segment since that time, staff recommends extending the agreement through October 31, 2019. The results of the RFI also showed no cost savings or improvements in process to justify the investment to change vendors.

HEDIS reporting has become somewhat of a commodity among the vendors in the marketplace. The differentiators are cost and relationship. CalOptima has a favorable pricing structure with Inovalon and a strong relationship that has enabled consistently positive HEDIS reporting and audit results. Additionally, changing vendors requires significant information services and operational investment and can be disruptive during the transition process.

Fiscal Impact
The CalOptima FY 2016-17 Operating Budget includes the annual fees for the existing HEDIS reporting vendor. Management will include expenses for the period of July 1, 2017, through October 31, 2019, related to proposed contract extension in the CalOptima FY 2017-18 and FY2018-19 Operating Budget when presented for Board consideration.

Rationale for Recommendation
The recommendation will enable continuity of HEDIS reporting and maintenance of a successful vendor relationship.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. June 2, 2011 CalOptima Board Action Agenda Referral, V. E., Authorize Extension of the Contract for Certified HEDIS Software
2. June 6, 2006 CalOptima Board Action Agenda Referral, VI. B., Approve the CalOptima Fiscal Year 2006-07 Capital Budget

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2011
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
V. E. Authorize Extension of the Contract for Certified HEDIS Software

Contact
Gertrude Carter, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to extend CalOptima's contract with MedAssurant for certified HEDIS software, Catalyst, through October 31, 2014, and to add two additional one-year extension options, exercisable at CalOptima's sole and absolute discretion.

Background
In 2006, the Board of Directors granted authority to issue a Request for Proposal (RFP) to procure and contract with a vendor for certified HEDIS software. Prior to using a certified vendor, CalOptima staff created source code for HEDIS reporting. However, with the inception of OneCare, HEDIS reporting requirements expanded significantly since the Centers for Medicare & Medicaid Services (CMS) requires full HEDIS reporting for Medicare Advantage Plans. CalOptima now reports over 40 measures across all programs: Medi-Cal, Healthy Families, and OneCare.

The use of a certified vendor reduces internal staffing burden, reduces NCQA HEDIS compliance audit risk (since the vendor is already certified by NCQA), and increases efficiencies.

As a result of the RFP process in 2006, CalOptima entered into an agreement on November 1, 2006 with MedAssurant for a term of five years. The contract currently expires on October 31, 2011.

Discussion
A contract extension would allow CalOptima to continue to use certified HEDIS software while recognizing efficiencies. CalOptima staff spends over 1000 work hours to build data tables and run the HEDIS software. While this work load is large, staff estimates that conversion to a new software application would require work hours in excess of 2000 hours.

In addition, the current software has become part of core business operations for medical data management. Catalyst is used for creating monthly registries of members with clinical gaps. These registries support the following business requirements:

- OneCare Model of Care
- HEDIS improvement initiatives

- DHCS-required Quality Improvement Projects
- MRMIB-required quality improvement initiatives
- Pay for Performance programs

Fiscal Impact
The cost of HEDIS software is a budgeted item for Fiscal Year (FY) 2010-11. The budgeted amount is $115,200. Annual costs are based on software license fees. For FY 2011-12, the estimated cost will be $110,400, which reflects changes in reporting requirements. In subsequent years, the costs will be built into the budget.

Rationale for Recommendation
This Board action will enable CalOptima to continue to use certified HEDIS software for required HEDIS reporting for the Medi-Cal, Healthy Families, and OneCare programs.

Concurrence
Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

Attachments
None

/s/ Richard Chambers — *5/24/11*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2006
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. B. Approve the CalOptima Fiscal Year 2006-07 Capital Budget

Contact
Keith Quinlivan, Chief Financial Officer (714) 246-8400

Recommended Action
Approve the CalOptima Fiscal Year 2006-07 Capital Budget.

Background
From the time of its start up through February 28, 2006, CalOptima has invested $14,700,000 in furniture, equipment and tenant improvements. Such fixed assets wear out over time, with the result that accumulated depreciation totaling $10,600,000 has been charged against the value of these purchases. The resulting net value of CalOptima's fixed assets was $4,100,000 as of February 28, 2006, reflecting a seventy-two percent (72%) rate of depreciation of such value over time.

Discussion
CalOptima staff is proposing a capital budget of $3,037,560 for FY 2006-07 in order to make needed improvements in the following three areas:

Computer Hardware	$1,004,560
Computer Software	1,507,000
Tenant Improvements	526,000
	$3,037,560

This budget will fund, among other things, upgrades to computer hardware and software to enhance operational decision-making and allow staff to better monitor HEDIS scores.

Fiscal Impact
Investment in the capital budget will reduce CalOptima's investment principal by $3,037,560. At a three percent (3%) return rate, this will reduce annual interest income by $90,000.

Rationale for Recommendation
The proposed FY 06-07 Capital Budget will enhance operational efficiencies by making an investment in CalOptima's infrastructure as proposed.

Concurrence
Foley & Lardner LLP
Board of Directors' Finance Committee

Back to Agenda Back to Item

Attachments

Attachment A: CalOptima Fiscal Year 2006-07 Proposed Capital Budget

/s/ Richard Chambers *5/31/2006*

Authorized Signature **Date**

Proposed CalOptima Fiscal Year 2006-2007 Capital Budget

Budget Items	Budget Amount	
Hardware Retirement / Replacements	$208,000	
HP RISS System (data archiving & retrieval)	$160,000	
Facets Production Cluster Upgrade (Hardware)	$150,000	
UPS Power Distribution System	$150,000	
Backup Data Storage Appliance	$100,000	
HEDIS Server	$50,000	
Network Based Fax Tool	$40,000	
Networked Color Printer Replacement	$27,200	
Mailing Machine	$27,000	
6 Laptops w/ Docking Stations	$25,860	
Laptop Pool Replacements	$20,000	
Remote Authentication Security (RAS)	$20,000	
CareLink Server	$19,500	
Replace HP Cabinets	$13,000	
Spare Enterasys Blade	$12,000	
InFocus LitePro Projectors	$9,000	
Total Computer Hardware		**$1,004,560**
HEDIS Software	$600,000	
Fraud Detection Software Pharmacy	$300,000	
Pre Payment Claims Audit Software	$150,000	
Facets Production Cluster Upgrade (Software)	$110,000	
Contract Management Software System	$75,000	
Batch Scheduler Software	$65,000	
Symposium Software Upgrade	$60,000	
Upgrade PBX to New Version	$40,000	
Call Monitoring System	$33,000	
BRS Upgrade/SQL Upgrade	$25,000	
W2K3 Server Software	$20,000	
Antigen for MS Exchange	$10,000	
Calendaring/File Tracking SW	$10,000	
AutoCad 2006 Software	$6,800	
Reader Board Software	$2,200	
Software		**$1,507,000**
Remodel Common Areas	$413,000	
A/V Equipment for Meeting Rooms	$78,000	
Building Monument Sign	$35,000	
Tenant Improvements		**$526,000**
	Grand Total	**$3,037,560**

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2011
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
V. E. Authorize Extension of the Contract for Certified HEDIS Software

Contact
Gertrude Carter, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to extend CalOptima's contract with MedAssurant for certified HEDIS software, Catalyst, through October 31, 2014, and to add two additional one-year extension options, exercisable at CalOptima's sole and absolute discretion.

Background
In 2006, the Board of Directors granted authority to issue a Request for Proposal (RFP) to procure and contract with a vendor for certified HEDIS software. Prior to using a certified vendor, CalOptima staff created source code for HEDIS reporting. However, with the inception of OneCare, HEDIS reporting requirements expanded significantly since the Centers for Medicare & Medicaid Services (CMS) requires full HEDIS reporting for Medicare Advantage Plans. CalOptima now reports over 40 measures across all programs: Medi-Cal, Healthy Families, and OneCare.

The use of a certified vendor reduces internal staffing burden, reduces NCQA HEDIS compliance audit risk (since the vendor is already certified by NCQA), and increases efficiencies.

As a result of the RFP process in 2006, CalOptima entered into an agreement on November 1, 2006 with MedAssurant for a term of five years. The contract currently expires on October 31, 2011.

Discussion
A contract extension would allow CalOptima to continue to use certified HEDIS software while recognizing efficiencies. CalOptima staff spends over 1000 work hours to build data tables and run the HEDIS software. While this work load is large, staff estimates that conversion to a new software application would require work hours in excess of 2000 hours.

In addition, the current software has become part of core business operations for medical data management. Catalyst is used for creating monthly registries of members with clinical gaps. These registries support the following business requirements:

- OneCare Model of Care
- HEDIS improvement initiatives

- DHCS-required Quality Improvement Projects
- MRMIB-required quality improvement initiatives
- Pay for Performance programs

Fiscal Impact
The cost of HEDIS software is a budgeted item for Fiscal Year (FY) 2010-11. The budgeted amount is $115,200. Annual costs are based on software license fees. For FY 2011-12, the estimated cost will be $110,400, which reflects changes in reporting requirements. In subsequent years, the costs will be built into the budget.

Rationale for Recommendation
This Board action will enable CalOptima to continue to use certified HEDIS software for required HEDIS reporting for the Medi-Cal, Healthy Families, and OneCare programs.

Concurrence
Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

Attachments
None

/s/ Richard Chambers — *5/24/11*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2006
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. B. Approve the CalOptima Fiscal Year 2006-07 Capital Budget

Contact
Keith Quinlivan, Chief Financial Officer (714) 246-8400

Recommended Action
Approve the CalOptima Fiscal Year 2006-07 Capital Budget.

Background
From the time of its start up through February 28, 2006, CalOptima has invested $14,700,000 in furniture, equipment and tenant improvements. Such fixed assets wear out over time, with the result that accumulated depreciation totaling $10,600,000 has been charged against the value of these purchases. The resulting net value of CalOptima's fixed assets was $4,100,000 as of February 28, 2006, reflecting a seventy-two percent (72%) rate of depreciation of such value over time.

Discussion
CalOptima staff is proposing a capital budget of $3,037,560 for FY 2006-07 in order to make needed improvements in the following three areas:

Computer Hardware	$1,004,560
Computer Software	1,507,000
Tenant Improvements	526,000
	$3,037,560

This budget will fund, among other things, upgrades to computer hardware and software to enhance operational decision-making and allow staff to better monitor HEDIS scores.

Fiscal Impact
Investment in the capital budget will reduce CalOptima's investment principal by $3,037,560. At a three percent (3%) return rate, this will reduce annual interest income by $90,000.

Rationale for Recommendation
The proposed FY 06-07 Capital Budget will enhance operational efficiencies by making an investment in CalOptima's infrastructure as proposed.

Concurrence
Foley & Lardner LLP
Board of Directors' Finance Committee

Back to Agenda Back to Item

Attachments

Attachment A: CalOptima Fiscal Year 2006-07 Proposed Capital Budget

Richard Chamberlain
Authorized Signature

5/31/06
Date

Attachment A

Proposed CalOptima Fiscal Year 2006-2007 Capital Budget

Budget Items	Budget Amount	
Hardware Retirement / Replacements	$208,000	
HP RISS System (data archiving & retrieval)	$160,000	
Facets Production Cluster Upgrade (Hardware)	$150,000	
UPS Power Distribution System	$150,000	
Backup Data Storage Appliance	$100,000	
HEDIS Server	$50,000	
Network Based Fax Tool	$40,000	
Networked Color Printer Replacement	$27,200	
Mailing Machine	$27,000	
6 Laptops w/ Docking Stations	$25,860	
Laptop Pool Replacements	$20,000	
Remote Authentication Security (RAS)	$20,000	
CareLink Server	$19,500	
Replace HP Cabinets	$13,000	
Spare Enterasys Blade	$12,000	
InFocus LitePro Projectors	$9,000	
Total Computer Hardware		**$1,004,560**
HEDIS Software	$600,000	
Fraud Detection Software Pharmacy	$300,000	
Pre Payment Claims Audit Software	$150,000	
Facets Production Cluster Upgrade (Software)	$110,000	
Contract Management Software System	$75,000	
Batch Scheduler Software	$65,000	
Symposium Software Upgrade	$60,000	
Upgrade PBX to New Version	$40,000	
Call Monitoring System	$33,000	
BRS Upgrade/SQL Upgrade	$25,000	
W2K3 Server Software	$20,000	
Antigen for MS Exchange	$10,000	
Calendaring/File Tracking SW	$10,000	
AutoCad 2006 Software	$6,800	
Reader Board Software	$2,200	
Software		**$1,507,000**
Remodel Common Areas	$413,000	
A/V Equipment for Meeting Rooms	$78,000	
Building Monument Sign	$35,000	
Tenant Improvements		**$526,000**
	Grand Total	**$3,037,560**

Back to Agenda Back to Item

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Inovalon	4321 Collington Rd.	Bowie	MD	20716

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contacts

David Ramirez, M.D., Chief Medical Officer, (714) 347-3261
Elizabeth Lee, Director, PACE, (714) 468-1100
Bridget Muscat, Director, Communications, (714) 246-8765

Recommended Action

Appropriate up to $228,000 in unbudgeted funds from existing reserves and authorize the Chief Executive Officer to make expenditures of these funds to support enhanced marketing efforts for the CalOptima Program of All-Inclusive Care for the Elderly through June 30, 2021.

Background

CalOptima's Program of All-Inclusive Care for the Elderly (PACE) was established in 2013 and currently serves approximately 385 participants via the CalOptima PACE Center and four operating alternative care settings (ACS) sites. PACE is a nursing home alternative for individuals requiring nursing home level care, but who are able to continue living in the community safely with appropriate support and assistance. The average age of PACE participants is 73 years.

CalOptima PACE enrollment has increased from 299 in early 2018 to 393 at the start of 2019. CalOptima PACE has exemplary health outcomes and has received awards, including the #1 participant satisfaction rating among PACE organizations in California and recognition from the National PACE Association as a "shooting star" and "supernova" for growth and access to PACE. CalOptima PACE ranks among the top PACE programs both in the state and nationally.

Per the PACE 2019 Quality Improvement Plan Evaluation, less than 1% of CalOptima's PACE participants resided in long-term care. It also reports that vaccination rates for pneumococcal and influenza were 95% and 97%, respectively. The FY 2020-21 CalOptima PACE operating budget projects revenue of $42.2 million, medical expenses of $37.7 million, administrative expenses of $2.0 million, and an operating margin of $2.5 million.

On April 4, 2019, the CalOptima Board of Directors took action to direct the CalOptima Chief Executive Officer to provide letters of support after consideration of requests for letters of support from AltaMed Health Services Corporation (AltaMed) and Innovative Integrated Health (IIH). Based on that board action, letters supporting AltaMed's and IIH's applications to establish independent PACE organizations in Orange County were sent to the Department of Health Care Services (DHCS) following staff's review of the requests. DHCS has received approval to expand PACE in Orange County, and AltaMed and IIH are in the application process. Assuming these applications are approved and AltaMed and IIH commence operations, CalOptima will no longer be the sole PACE facility operating in Orange County and will have to modify its marketing strategy to retain current PACE participants and obtain new enrollment.

Back to Agenda

DHCS notified CalOptima on August 6, 2020, that the Centers for Medicare & Medicaid Services (CMS) approved California's request to amend its Medi-Cal 2020 section 1115(a) Demonstration Waiver to expand PACE in Orange County. CalOptima was also notified that AltaMed's application to operate a PACE organization in Orange County was accepted and is currently under review, with operations expected to commence in January 2021. Approval of the application will result in a Medi-Cal contract between AltaMed and DHCS, separate from CalOptima. Staff also understands that IIH has submitted an application to operate PACE in Orange County.

All 24 ZIP Codes included in the AltaMed application and 44 ZIP Codes in the IIH application overlap with CalOptima's PACE service area, which includes all of Orange County. National PACE Association projections, based on US Census Data in 2019, estimate that the total number of individuals in Orange County who are potentially eligible to enroll in PACE is approximately 6,000. Nationwide, market penetration of eligible individuals enrolling in PACE is approximately 10–15% for mature PACE organizations.

Discussion

With more than one provider of PACE services soon to be operating in the same geographical area, CalOptima must now shift its approach to operating PACE in a competitive market, including changes to how CalOptima markets the PACE program. With respect to participant enrollment, CalOptima's marketing efforts have traditionally focused on the general PACE model rather than on CalOptima's PACE brand. CalOptima will need to refine its marketing approach to the same standard and presence as independent PACE Organizations (PO). As detailed in Attachment 4, CalOptima staff proposes to launch an enhanced marketing campaign focused on the following:

1. Membership retention
2. Year-round presence
3. Increase direct mail
4. Update collateral materials
5. Television/video

With respect to retention, PACE participants are permitted to change enrollment from one PO to another PO within their service area. CalOptima staff intends to incorporate value-added medically necessary services for CalOptima PACE participants to focus on retention in 2021 PACE Quality Initiative Plan.

Additionally, PACE personnel require specific training and qualifications to engage in direct care. Staff will have more PO employment opportunities in Orange County, creating a potential impact on recruitment and retention of CalOptima PACE employees. Staff plans to recommend future Board action to implement a competitive strategy to engage and retain PACE personnel.

CalOptima PACE exemplifies quality and efficiency, as evidenced by the #1 ranking PACE program in California for participant satisfaction, as well as national recognition for creating access to care for elderly beneficiaries. CalOptima PACE is an example of a successful public-private partnership and as a responsible steward of public funds.

Back to Agenda

The CalOptima Fiscal Year (FY) 2020-21 Operating Budget included $363,000 for PACE public activities, member communication and advertising. Staff recommends authorization for an additional $228,000 to support enhanced marketing efforts.

Fiscal Impact

The recommended action is an unbudgeted item. As proposed, an allocation of up to $228,000 from reserves will fund this action.

Rationale for Recommendation

CalOptima must be responsive to changes in the health care marketplace, protecting existing investments by enhancing marketing activities to match the competitive market.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Previous Board Action dated April 4, 2019 Consider Requests for Letters of Support from Organizations Seeking to Offer Program of All-Inclusive Care for the Elderly (PACE) Services in Orange County Independent of CalOptima
2. Presentation –PACE in Overlapping Service Area Report
3. Entities Covered by this Recommended Board Action
4. PACE Enhanced Marketing Budget Request Detail

/s/ Richard Sanchez *10/28/2020*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

24. Consider Requests for Letters of Support from Organizations Seeking to Offer Program of All-Inclusive Care for the Elderly (PACE) Services in Orange County Independent of CalOptima

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Consider requests for letters of support from organizations seeking to offer PACE services in Orange County independent of CalOptima.
2. If requests for letters of support are approved, authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to submit CalOptima letter(s) of support to the Department of Health Care Services.

Background

The Department of Health Care Services (DHCS) issued PACE policy letters regarding the PACE application process on October 27, 2017, and on August 17, 2018, that outline the process for an independent PACE facility to operate in County Organized Health System (COHS) counties including Orange County. Historically, the only entity that could operate a PACE program in a COHS county was the designated Medi-Cal managed care plan. California Welfare & Institutions Code section 14087.5 *et seq*. provides that when a COHS plan is established in a county, that COHS plan holds the exclusive right to contract for Medi-Cal services, including PACE, in the respective county.

However, the above-referenced DHCS policy letters describe a process by which an organization interested in becoming an independent PACE Organization (PO) in a COHS county may, with the formal support of the local COHS plan, be considered to operate in that county(s). Specifically, DHCS will only consider an application from an independent PO in a COHS county if its application to DHCS includes a letter of support from the COHS Medi-Cal managed care plan. In the letter, the COHS plan must take the significant step of requesting that DHCS submit a formal request to the federal Centers for Medicare & Medicaid Services (CMS) requesting an amendment to California's existing Section 1115 Medicaid Waiver as part of the independent PO application process to make an exemption to the existing law that governs COHS plans. COHS plans, including CalOptima, are under no obligation to provide such letters of support.

Specific to the application process for organizations seeking to operate in COHS counties, the COHS role is to issue (or not issue) a letter of support. If the COHS plan does not issue a letter of support, DHCS will not approve the application; if the COHS does provide a letter of support, it will be up to the state and federal regulators to make all subsequent decisions on the application.

Back to Agenda Back to Item

In response to the DHCS policy letters, on September 6, 2018 the Board approved a process to consider requests for letters of support from organizations seeking to establish PACE operations in Orange County independent of CalOptima. Elements of the process include, but are not limited to:

- Geographic ZIP code designation, consistent with the DHCS and CMS PACE organization application process and policy, independent PO letter of support requests will include the specific zip codes;
- Threshold Criteria (50% weighting), including PACE operating experience, financial soundness quality performance/metrics and demographic competence; and,
- Primary Criteria (50% weighting), including the potential impact on CalOptima PACE program/operations and independent POs operating in Orange County, if any.

Requests for letters of support were accepted from November 1, 2018 through January 31, 2019.

Discussion

CalOptima received requests for letters of support from two organizations, AltaMed Health Services (AltaMed) and Innovative Integrated Health, Inc. dba Fresno PACE (Fresno PACE). Both organizations submitted documentation for the requested elements.

Geographic ZIP code designation

AltaMed Health Services	Innovative Integrated Health, Inc. dba Fresno PACE
• PO seeks to operate in zip codes in Anaheim and Santa Ana • 48.7% of current CalOptima PACE participants reside in these cities • All requested zip codes overlap CalOptima service areas	• PO seeks to operate in one or more zip codes in 16 of the 34 cities in Orange County including: Anaheim, Brea, Buena Park, Cypress, Fullerton, Irvine, La Palma, Lake Forest, Los Alamitos, Midway City, Orange, Placentia, Stanton, Villa Park, Westminster, Yorba Linda • 47.1% of current CalOptima PACE participants reside in these cities. • All requested zip codes overlap CalOptima service areas

Threshold Criteria

Criteria	Response	
	AltaMed Health Services	Innovative Integrated Health, Inc. dba Fresno PACE
PACE operating experience	Information submitted; no areas of concern identified in the information submitted	Information submitted. PO will have five (5) years experience in November 2019
Financial Soundness	Information submitted; no areas of concern identified in the information submitted	Information submitted; no areas of concern identified in the information submitted.
Quality Performance/Metrics	PO outperformed CalPACE average performance for all criteria requested with the exception of readmission rate; note readmission rates are highly variable due to the small baseline population	PO outperformed CalPACE average performance for all criteria requested.
Demographic competence	Information submitted; no areas of concern identified in the information submitted	Information submitted; no areas of concern identified in the information submitted

Primary Criteria

In addition to the above, independent POs were required to provide information related to the potential impact on CalOptima PACE program/operations and independent POs operating in Orange County, if any.

AltaMed

AltaMed's request indicates an intention to focus on Anaheim and Santa Ana. These cities border Garden Grove, the primary service location for CalOptima PACE. Nearly 49% of CalOptima PACE enrollees are from the two proposed cities. AltaMed also indicated it would establish a particular focus on low-income Hispanic population. More than 50% of CalOptima PACE participants list Spanish as their primary language and approximately 80% of CalOptima PACE staff are bilingual, primarily Spanish speaking. Further, AltaMed's request notes that many of the participants in its existing PACE programs originate from referrals from primary care providers; it further specifically notes that AltaMed's Federally Qualified Health Clinics (FQHCs) in Anaheim and Santa Ana would serve as an "excellent built-in" referral system for an AltaMed PACE. Additionally, CalOptima PACE received regulatory approval to use community-based physicians to increase access and support continuity of care for PACE participants

Fresno PACE

Fresno PACE's request states that it has not chosen zip codes, especially in Garden Grove and Santa Ana, which represent a high percentage of CalOptima PACE. Approximately 47% of CalOptima PACE participants reside in the cities identified by Fresno PACE. Additionally, CalOptima PACE recently partnered with Sultan Adult Day Care in Anaheim, a contracted Community-Based Adult Services (CBAS) provider, as an Alternate Care Setting (ACS). Sultan Adult Day Care is a registered dba of Pacific GIS, Inc. Per Pacific GIS's licensing documentation at the California Department of Aging, several of its officers and directors are also officers and/or directors of Fresno PACE.

Potential Impact on CalOptima PACE

CalOptima staff has identified the following impact of adding independent POs in Orange County.

- Modification to COHS model: COHS plans hold the exclusive right to contract for Medi-Cal services in the county. If approved, CalOptima will need to specifically request that DHCS submit to the federal government a request to amend California's section 1115 Waiver to allow the independent operation of a specified PO in Orange County.

- No control over sites or service areas: There is no indication that DHCS would require a new letter of support if an approved independent PO later seeks to expand its service area. Thus, it is possible that these POs could request expansion beyond the current request without input from CalOptima.

- Increased administrative costs for CalOptima PACE: Both POs have expressed interest in central Orange County where a significant number of CalOptima PACE participants reside, which may require that CalOptima PACE make a greater investment into marketing. CalOptima PACE maintains a very low marketing budget. In the most recent National PACE Association National Benchmarking Report, CalOptima expended only $14.00 per member per month for marketing expenses compared to the national median of $43.50 per member per month.

Overall Summary

As proposed, independent POs would overlap with CalOptima PACE and raise the potential of adverse selection of membership served. While there currently is no "wait list" for qualifying individuals interested in participating in PACE in Orange County, independent POs in Orange County may bring greater awareness of the PACE program, and add choice and preference for mostly low-income seniors in Orange County.

Staff recommends that the Board consider whether to submit to DHCS a letter of support in response to the request of each organization seeking to offer PACE services in Orange County independent of CalOptima in accordance with regulatory guidance.

Fiscal Impact

In the event the Board approves the request(s) for letters of support from one or both POs and authorizes the CEO to submit such letter(s) to DHCS, the fiscal impact is unknown at this time. The addition of one or two PACE facilities operating in overlapping service areas with CalOptima's current PACE

program will likely have an adverse effect on current levels of enrollment, revenue, and income. Lower enrollment or decelerating enrollment growth would decrease revenues and increase unit cost, directly affecting administrative expenses as many PACE services rely on maximizing economies of scale. In addition, a reduction in net income will elongate the payback period for CalOptima's capital investments in the PACE program.

Rationale for Recommendation

Consistent with the October 27, 2017 and August 17, 2018 PACE Policy Letters, to determine whether or not the CalOptima Board will authorize CalOptima to submit to DHCS a Letter of Support in response to each organization's request in connection with such organization's interest in becoming an independent PACE Organization in Orange County.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated February 1, 2018, Consider Authorizing Contracts with Alternate Care Settings (ACS) to Support Expansion and Growth of CalOptima Program of All-Inclusive Care for the Elderly (PACE)
2. Board Action dated September 6, 2018, Consider Approval of Process for Considering Requests for Letters of Support from Organizations Seeking to Offer Program of All-Inclusive Care for the Elderly (PACE) Services in Orange County Independent of CalOptima

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Contracts with Alternative Care Settings (ACS) to Support Expansion and Growth of CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Enter into contracts with Community Based Adult Services (CBAS) centers to serve as Alternative Care Setting (ACS) sites for CalOptima PACE members; ~~and~~
2. Contract with additional ACS sites on established operational and quality standards and potential PACE participant needs, subject to Board approval; and
3. Staff to report performance metrics back to the Board.

Rev. 2/1/2018

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. The CalOptima PACE Center provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. CalOptima opened its PACE center on October 1, 2013, and currently serves approximately 238 members at the single location.

At its February 4, 2016 meeting, the Board authorized submission of a service area expansion to the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS), authorized a Request for Proposal (RFP) process for the ACS model for PACE expansion satellite locations to include CBAS centers, and directed staff to perform additional analysis. Subsequently, at its May 4, 2017 meeting, the Board requested that staff first issue a Request for Information (RFI) on alternative care settings. The RFI was released on May 26, 2017. Findings from the RFI, including a market analysis, locations and capabilities of potential ACS sites, were used to develop a RFP, which was released on November 3, 2017. Staff has completed scoring of the proposals and qualified five CBAS centers based on:

- CBAS center currently serving CalOptima members located in or adjacent to the service area
- Operational for a minimum of one year
- Capacity to provide services to a minimum of 15 CalOptima PACE members

Back to Agenda Back to Item

- Fiscal soundness, as evidenced by evaluation of financial statements for three consecutive years, as well as a third-party risk report when available. Metrics evaluated include liquidity, debt ratio, short-term viability, and delinquency.
- Capable of providing six of the seven PACE core services per PACE regulatory requirements and evaluated according to descriptions of the operational, security, financial, compliance and analytics requirements of the RFP.
- In good standing with regulatory agencies, as evidenced by no active corrective action plans or sanctions.
- Capacity to increase access to services based on cultural competency, geographical area or medical condition.

The five CBAS centers that qualified through the RFP process are listed in Attachment 1.

While CalOptima's current service area is limited to north Orange County, the ACS model is expected to be an important step toward increasing access to PACE services throughout Orange County. CalOptima's request for expansion of the service area to include all Orange County Zip Codes is currently under review by CMS, with approval anticipated as soon as July 1, 2018. Four of the five CBAS centers qualified through the RFP are in the current service area, with one in the proposed expanded service area.

Discussion

Using alternative care settings for CalOptima PACE members is expected to increase access to culturally and linguistically competent, specialized services in close geographical proximity to participants' residences. CMS defines an alternative care setting as a facility, other than the participants' primary residence, where PACE participants receive the services listed in section 460.98 of U.S. Code: Title 42 (Public Health and Welfare).

In accordance with section 460.98, an ACS can provide six of the seven core PACE services, with the seventh, primary care, provided by the CalOptima PACE site. ACS sites will provide the following six services:

- Social services
- Restorative therapies, including physical therapy and occupational therapy
- Personal care and supportive services
- Nutritional counseling
- Recreational therapy
- Meals

Interdisciplinary Team assessment and care planning will remain components provided directly by the PACE center. Primary care may be provided by CalOptima PACE or a community-based physician, on an individualized basis. Transportation services will be provided by CalOptima PACE or by ACS sites, based on the ability to fulfill operational and quality standards. The proposed contracts include rates and terms for ACS sites deemed capable of providing transportation services.

Through the RFP process, staff have developed a program design for CalOptima PACE to utilize ACS, including operational and quality standards required to be designated as an ACS. In the future, ACS sites may potentially be added based on a tool that determines operational and quality standards required to operate as an ACS, allowing CalOptima PACE to respond to access needs in specific areas of the county.

Fiscal Impact

The recommended actions to authorize contracts with CBAS centers to serve as PACE ACS sites are expected to increase enrollment in the PACE program, while maintaining current financial performance. Pro forma projections for Fiscal Year 2018-19 assume a net increase of two members per month related to the addition of the ACS sites. Increasing access to PACE services through the ACS strategy is expected to allow more eligible county residents to participate in the CalOptima PACE program, and may improve operational efficiencies and increase economies of scale. CalOptima will pay contracted ACS sites a per diem rate derived from CalOptima PACE's experience and projected unit costs for day center attendance, which includes six of the seven core PACE services. Given the modest anticipated enrollment increase, Management projects that the medical loss ratio, administrative loss ratio, and net margin will remain consistent with current levels through the fiscal year.

Rationale for Recommendation

Alternative care settings will increase access to care for current PACE members. Specifically, these services are culturally competent and specialized, possibly in more convenient geographical locations to PACE members' residences. In addition, the alternative care setting strategy has been identified as a vehicle for expanding the PACE model of care to all Zip Codes of Orange County. Currently, service area is limited to 60-minute one-way ride radius from the PACE center in Garden Grove. With ACS 'satellite' sites throughout Orange County, eligible CalOptima members will have access to the coordinated quality care provided by CalOptima PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. RFP-Qualified CBAS Providers
2. PowerPoint Presentation: PACE Alternative Care Setting (ACS) RFP Results

/s/ Michael Schrader *1/25/2018*

Authorized Signature **Date**

Back to Agenda Back to Item

RFP-Qualified CBAS Providers

Center Name	Contract Name	Contract Effective Date	Center Address
Acacia Adult Day Services	Acacia Adult Day Services	7/1/12	11391 Acacia Parkway Garden Grove, CA 92840
Anaheim VIP Adult Day Health Care	Community Seniorserv, Inc., dba Anaheim VIP Adult Day Health Care	7/1/12	1158 North Knollwood Circle Anaheim, CA 92801
Santa Ana/Tustin VIP Adult Day Health Care	Community Seniorserv, Inc., dba Santa Ana/Tustin VIP Adult Day Health Care	7/1/12	1101 South Grand Avenue, Suite L Santa Ana, CA 92705
South County Adult Day Services	Alzheimer's Orange County	7/1/12	24260 El Toro Road Laguna Woods, CA 92637
Sultan Adult Day Health Care Center	Pacific GIS, Inc., dba Sultan Adult Day Health Care Center	7/1/12	125 W. Cerritos Avenue Anaheim, CA 92805

PACE

CalOptima

A Public Agency

Better. Together.

PACE Alternative Care Setting (ACS) RFP Results

Board of Directors Meeting

February 1, 2018

Richard Helmer, M.D., Chief Medical Officer

Elizabeth Lee, Director, PACE

Goal of Implementing ACS

- To expand access to PACE to all eligible Orange County seniors
  - Geographic coverage in current North County service area and future South County service area, anticipated in July 2018

- To ensure PACE supports participants' unique needs
  - Culture competence
  - Language access
  - Health conditions

ACS Background

- Staff progress on Board-approved ACS directives
  - September 2016: Presented financial information to Finance and Audit Committee (FAC)
  - February 2017: Updated FAC with additional financial performance metrics
  - May 2017: Conducted a three-hour PACE Study Session for the full Board, with a presentation by the state regulator and analysis of ACS by National PACE Association
  - May 2017: Issued a Request for Information (RFI) from potential ACS partners
  - August 2017: Distributed a 300-page PACE informational binder to the Board
  - November 2017: Released a Request for Proposal (RFP) for ACS partners

PACE and CBAS Alignment

- PACE and Community-Based Adult Services (CBAS) centers serve similar populations
  - Are nursing home-eligible
  - Have multiple chronic conditions
  - Need help with activities of daily living
- PACE and CBAS centers have an opportunity to better meet participants' preferences and needs
  - Increased convenience and appropriateness for participants
    - Conditions, language and ethnicity, and residence
- PACE and CBAS centers seeking new avenues for growth
  - CBAS centers are a referral source to PACE
  - Partnership provides CBAS centers with stable revenue

CBAS as an ACS

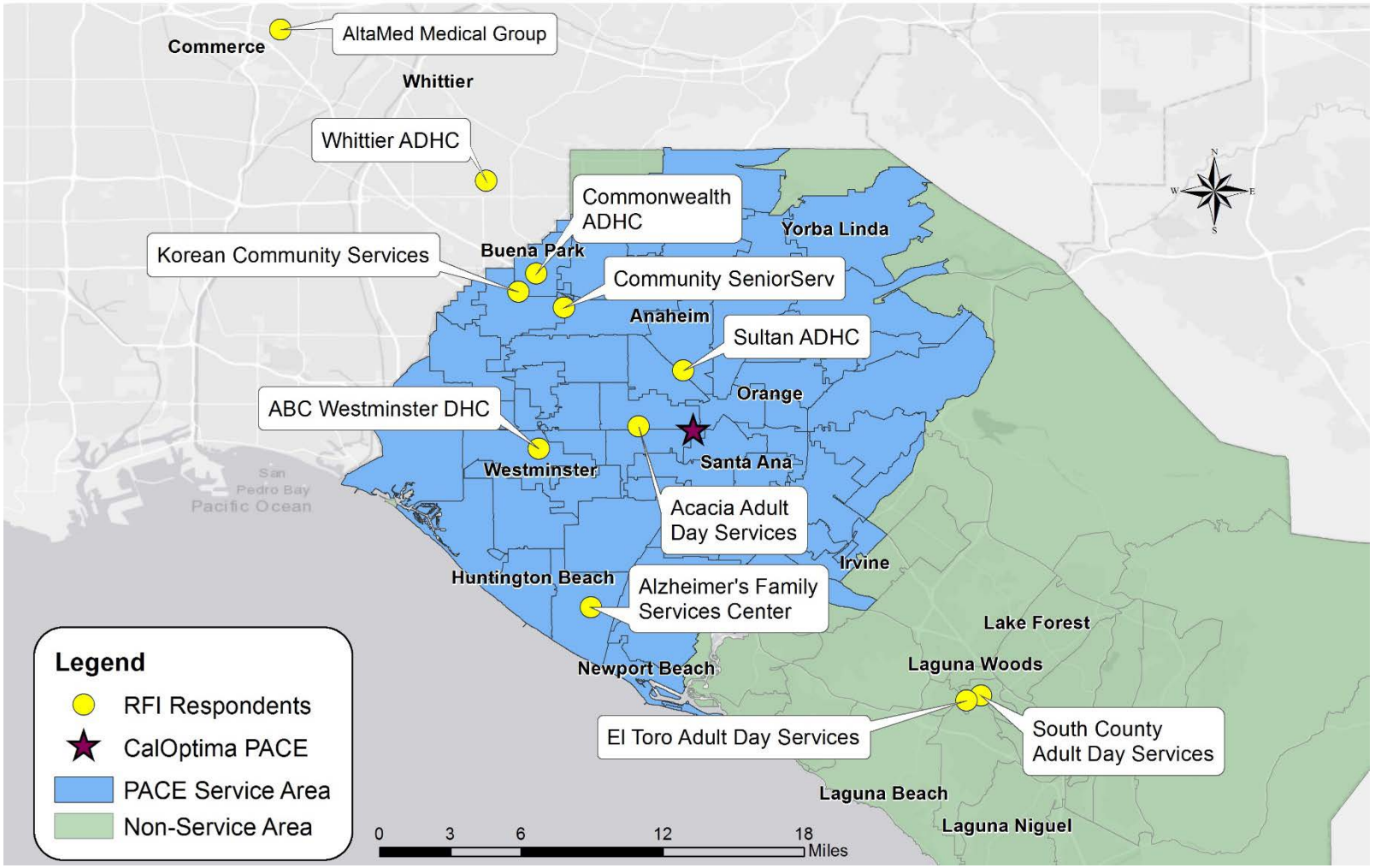
- CBAS centers deliver six of seven core PACE services
  - Social services
  - Restorative therapies
  - Personal care and supportive services
  - Nutritional counseling
  - Recreational therapy
  - Meals

- CalOptima PACE retains responsibility for the seventh core service
  - Primary care

RFI Background

- CalOptima issued an RFI for ACS sites in May 2017
- Responses were collected, with all Orange County respondents interviewed as of August 2017
- There were a total of 11 respondents, nine located in Orange County
  - Of those nine, eight were licensed CBAS centers

RFI Respondents/PACE Service Area



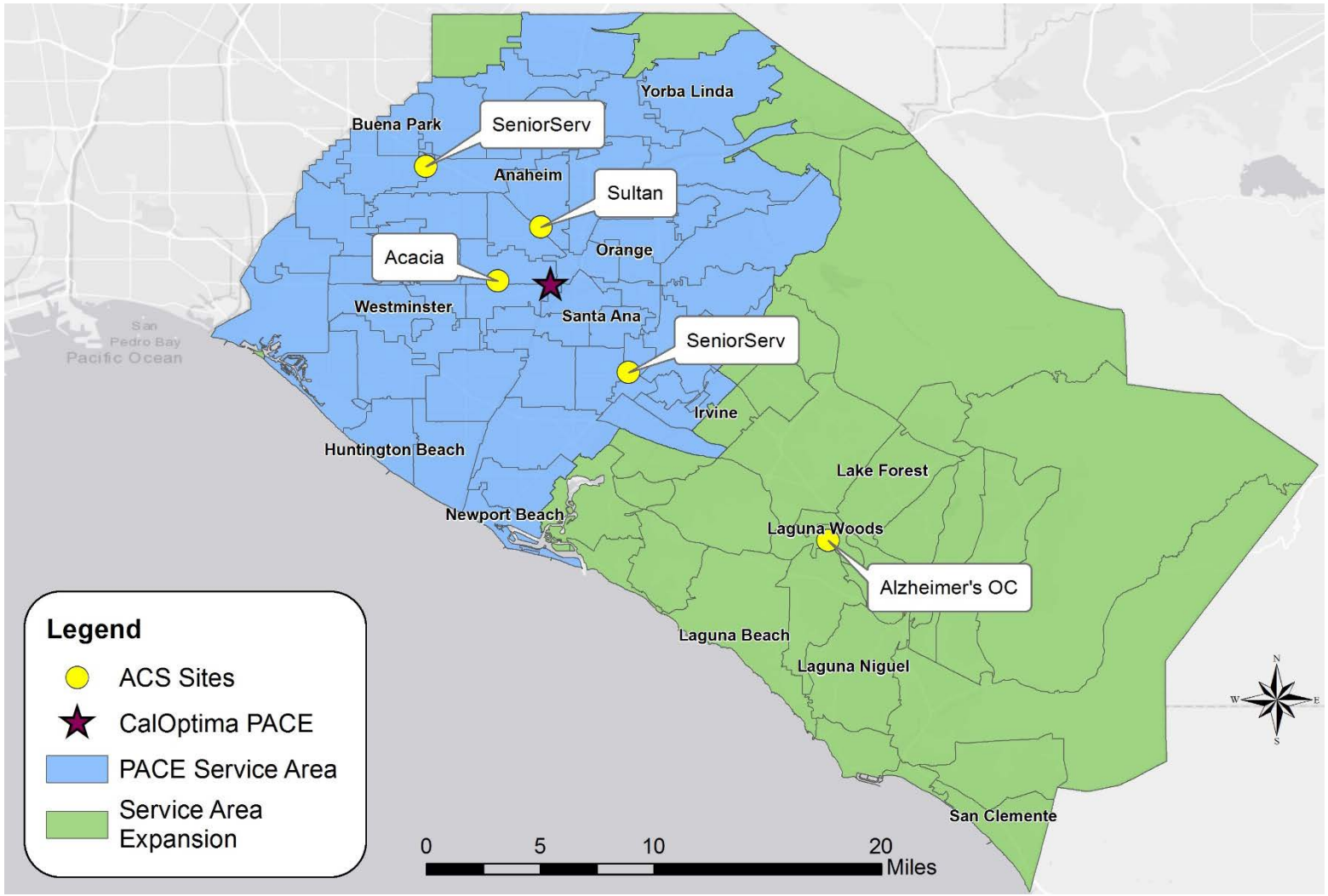
RFI Findings

- Interest level provided a solid basis from which to move forward on a countywide RFP
- Respondents seemed to understand the ACS concept and have elements in place to participate
- Information from respondents helped the development of a program design, including operational, quality and capacity standards, for the RFP

RFP Background

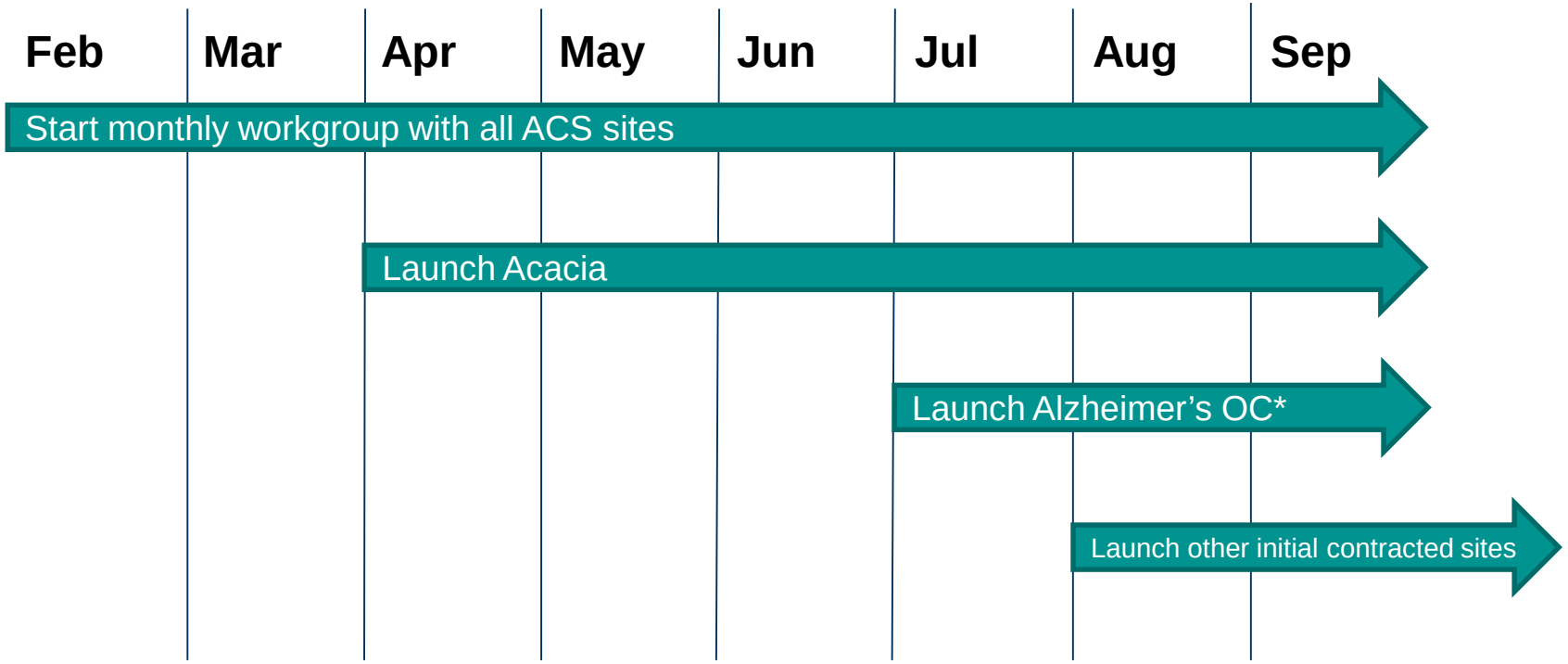
- CalOptima issued an RFP for ACS sites in November 2017
  - RFP included detailed criteria
    - Operational
    - Security
    - Financial
    - Compliance
    - Analytics
  - RFP included a proposed contract amendment, which defined rates and requirements
- There were eight respondents
- Site visits were conducted with respondents meeting the initial criteria
- Five respondents were deemed qualified

Proposed ACS Sites



Phased Implementation

- Phased implementation supports use of best practices
- Monthly workgroup fosters collaboration from the start



** Pending CMS approval of service area expansion*

Additional ACS Sites

- Program design allows for additional ACS sites to be added based on an application process that:
  - Assesses operational and quality standards
  - Considers potential PACE participant needs
  - Supports efficient use of time and resources
  - Accommodates future growth

Staff Recommendation

- Authorize the Chief Executive Officer, with the assistance of legal counsel, to:

  - Enter into contracts with CBAS centers to serve as ACS sites for CalOptima PACE members, and;

  - Contract with additional ACS sites on established operational and quality standards and potential PACE participant needs.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

15. Consider Approval of Process for Considering Requests for Letters of Support from Organizations Seeking to Offer Program of All-Inclusive Care for the Elderly (PACE) Services in Orange County Independent of CalOptima

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Action

Authorize the CEO to implement a process to consider requests for letters of support from organizations seeking to offer PACE services in Orange County independent of CalOptima, with all final decisions subject to Board approval.

Background

PACE is a comprehensive health care program that CalOptima provides for frail seniors in Orange County. The PACE model is a person-centered, community-based alternative to nursing home care. PACE supports elders and their families by providing preventive and primary care, and coordinating behavioral health and acute care, as well as long-term services and supports. The intensive care coordination helps individuals with complex chronic care needs to continue living in the community as long as possible. CalOptima opened Orange County's first PACE center in October 2013, and the program has grown to nearly 300 participants. CalOptima recently launched several new initiatives designed to expand access to PACE, including partnerships with Community-Based Adult Services (CBAS) centers, a greater role for community-based physicians in caring for PACE participants, and a larger PACE service area to reach all eligible seniors in Orange County.

On October 27, 2017, and on August 17, 2018, the Department of Health Care Services (DHCS) issued PACE policy letters regarding the PACE application process, including guidance on operation of an independent PACE facility in County Organized Health System (COHS) counties including Orange County. Historically, the only entity that could operate a PACE program in a COHS county was the designated Medi-Cal managed care plan. Welfare & Institutions code section 14087.5 *et seq*. provides that a managed care plan that elects to organize as a COHS holds the exclusive right to contract for Medi-Cal services, including PACE, in the respective county.

However, the above-referenced DHCS policy letters describe a process by which an organization interested in becoming an independent PACE Organization (PO) in a COHS county may, with the formal support of the local COHS plan, be considered to operate in that county(s). Specifically, DHCS will only consider an application from an independent PO in a COHS county if its application to DHCS includes a letter of support from the COHS Medi-Cal managed care plan. In the letter, the COHS plan must take the significant step of requesting that DHCS submit a formal request to the federal Centers for Medicare & Medicaid Services (CMS) requesting an amendment to California's existing Section 1115 Medicaid Waiver as part of the independent PO application process to make an exception to the existing

law that governs COHS plans. COHS plans, including CalOptima, are under no obligation to provide such letters of support.

Specific to the application process for organizations seeking to operate in COHS counties, the COHS plans' only role is to issue (or not issue) a letter of support. If the COHS plan does not issue a letter of support, DHCS will not approve the application; if the COHS does provide a letter of support, it will be up to state and federal regulators to make all subsequent decisions on the application.

Since the release of the DHCS policy letters, staff has received informal inquiries from groups interested in applying to become independent POs in Orange County on how and whether CalOptima intends to respond to any requests for letters of support requesting that DHCS seek formal modification of California law governing the COHS framework.

Should CalOptima decide to provide one or more letters of support to independent POs, the decision would then be out of CalOptima's hands, and the independent POs would follow an application process first involving DHCS, and if DHCS submits the request, CMS would consider whether to approve the requested waiver amendment. If CMS approves the waiver amendment, DHCS would then evaluate the independent PO application, and if approved, the application would go to CMS for final approval.

Separate from considering requests from independent POs, CalOptima staff is continuing Board-approved expansion efforts through collaboration with community partners. These include expanding CBAS center use through Alternative Care Setting sites, continuing to cultivate referrals from contracted community-based physicians, enrollment efforts in South Orange County, increasing current sales and marketing efforts, adding a Veteran's Choice option to encourage enrollment by veterans, and adding a Medicare-only members option.

Discussion

In response to the DHCS policy letters and independent PO inquiries, staff is recommending that the Board approve an internal review process for the evaluation of requests for letters of support from organizations seeking to establish independent PACE operations in Orange County and making recommendations to the Board.

Elements of the process to consider letter of support requests include, but are not limited to:

1. **Application timeline window:** Subject to Board approval, staff anticipates accepting letters of support requests beginning November 1, 2018, to January 31, 2019.
2. **Geographic ZIP code designation:** Consistent with the DHCS and CMS PACE organization application process and policy, independent PO letter of support requests will include the specific ZIP codes the independent PO is interested in serving.
3. **Threshold Criteria (~~20~~50% weighting):** All letter of support requests from independent POs shall include and will be evaluated based on the following criteria:
    a. PACE operating experience
        i. Show a minimum of five (5) years of operating experience
        ii. Provide proof of regulatory audits with no sanctions

Rev. 9/6/18

iii. Submit operational policies and procedures
iv. Obtain reference letters from member advocates, providers and community stakeholders

b. Financial soundness
   i. Submit financial statements (income statements and balance sheets) for the three most recent consecutive years
   ii. Report financial metrics (i.e. liquidity, debt ratio, short-term viability, delinquency)
   iii. Obtain third-party risk report via Dunn and Bradstreet (where available)

c. Quality performance/metrics
   i. Report performance against current CalPACE averages in areas of participants residing in nursing homes, hospital admissions, hospital days, hospital readmission rate, emergency room visits and participant satisfaction rating

d. Demographic competence
   i. Provide a general PACE demographic profile data of the ZIP code area of interest
   ii. Demonstrate staff experience and/or understanding in serving PACE participants similar to those in the potential geographic area
      1. Training in cultural competency
      2. Language capability
      3. Accommodations for low literacy
      4. Response to socioeconomic factors

4. **Primary Criteria (~~80~~ 50% weighting):** Potential impact on CalOptima PACE program/operations and other POs operating in Orange County, if any. Rev. 9/6/18
   a. For POs with strong demonstrated performance on the Threshold Criteria, the focus would be on, for example, evaluation overlap with existing PACE facilities in the County (e.g., also considering likelihood of adverse member selection, geographic separation, etc.); how the PO's application demonstrates that they are proposing to offer complementary PACE services (e.g., for unique member populations, serving remote/underserved geographic areas of the County, bringing new providers, or in some other meaningful ways, enhancing existing PACE facilities).

5. **Return to the Board with Recommendations**. After analyzing PO proposals and requests for letters of support, staff will return to the Board with recommendations.

Fiscal Impact

The recommended action is projected to be budget neutral. CalOptima's Fiscal Year 2018–19 Operating Budget, approved by the Board on June 7, 2018, included projected revenues and expenses related to the continuation of PACE expansion.

Staff anticipates that the administrative expenses included in the Board-approved operating budget are sufficient to cover the anticipated costs related to the recommended action.

Rationale for Recommendation

Staff recommends that the Board adopt a process for considering requests for letters of support from organizations seeking to offer PACE services in Orange County independent of CalOptima. As a public agency, CalOptima should be prepared to respond to such potential requests.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS PACE Policy Letter 17-03, issued on October 27, 2017.
2. DHCS PACE Policy Letter 18-01, issued on August 17, 2018.
3. Presentation: PACE Response to Regulatory Guidance

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

8/29/2018 — **Date**

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Date: October 27, 2017

Policy Letter 17-03
Replacing PACE Policy Letter 16-01

To: Program for All-Inclusive Care for the Elderly (PACE) Organizations

Subject: PACE Application Process

Purpose

The purpose of this Policy Letter is to inform Program of All-Inclusive Care for the Elderly (PACE) Organizations (POs) and potential applicant organizations of the revised Department of Health Care Services (DHCS) application review process and timeline for new PO applications and PACE Expansion applications.

Background

In 2016, the California Legislature passed the PACE Modernization Act Trailer Bill (Sections 31-36 of SB 833, Chapter 30, Statutes of 2016) including updates to the payment and regulatory structure of PACE. The updated California PACE statutes, in part, removed the cap on the number of POs that could operate in the state, and allowed for-profit entities to become POs. As a result, DHCS has seen renewed interest in PACE and an increase in new/expansion applications submitted to DHCS for review. Therefore, DHCS is issuing revised guidance to clarify the Department's expectations with respect to the competitive nature of the review process.

The Centers for Medicare & Medicaid Services (CMS) released the 2017 PACE Application Guidance on January 17, 2017, to address its electronic PACE application submission timelines and review process. Effective immediately, all new and expansion PACE applications are required to be submitted to CMS through the web-based Health Plan Management System (HPMS). Applicants should review this guidance and be aware of CMS requirements for accessing HPMS. The downloadable PDF of the application and additional information can be found at: https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html

Application Review Process

All new and expansion PACE applications must go through an initial review process by DHCS in order to move forward with submission to CMS via HPMS. The initial submission components are detailed in this letter, which aims to provide DHCS with key organizational background and financial viability documentation. This information is necessary for the State to complete/sign the State Assurance pages and authorize the submission of the full application to DHCS and CMS via HPMS.

Integrated Systems of Care Division
1501 Capitol Avenue, MS 0018 PO Box 997413
Sacramento, CA 95899-4713
(916) 552-5105
Internet Address: http://www.DHCS.ca.gov

Upon submission of the full application to CMS, the State will align its review of the remaining application with the CMS initial 45/90-day clock cycle, dependent on type of application, to create a concurrent review process. The initial CMS 45/90-day clock review begins upon receipt of the completed full application in HPMS, which must include the signed State Assurance pages.

DHCS will review the application according to state and federal laws and regulations. Prior to entering into a contract for the provision of Medi-Cal managed health care services, DHCS may consider any factor it determines to be necessary for consideration (Welfare & Institutions Code §§ 14095 and 14592(b)). This includes considering any information relevant to the issue of whether the application could result in unnecessary duplication of services or impair the financial or service viability of an existing program (42 USCA § 1395eee(e)(2)(B)).

Initial State Review

All new and expansion applications received by DHCS will follow the below initial state review timeframes for application submission:

Action	**Due Date**	**Documents for Submission**	**Reviewer**	**Review Timeframe**
Notification of Intent to DHCS	30 days prior to Initial Application Submission to DHCS	• Letter of Intent • Letter for Support from COHS (if applicable)	DHCS	N/A
Initial Application Submission to DHCS	60 days prior to CMS application submission deadline	• Market Feasibility Study • Letters of Support • Application sections (see Attachment 1)	DHCS	60 Calendar Days
Full Application Submission in HPMS	Align with CMS PACE Application Submission Deadline	• Remaining application sections • State Assurance Page	DHCS/CMS	Align with CMS 45/90 day review clock

Concurrent Federal and State Review

The CMS review process of the PACE Application will include a series of attestations and uploads based on the type of application received, (Initial Application or Service Area Expansion).

Upon completion of the initial CMS 45/90-day clock review of the full application, CMS and/or DHCS may issue a Request for Additional Information (RAI) to the applicant. In the event a RAI is issued, the application is taken off the review clock during this period while the applicant responds to either the CMS and/or DHCS RAI. DHCS will align its remaining review and RAI (if necessary) with CMS timelines and ensure that any necessary changes are communicated to CMS.It is also during this period that DHCS conducts the Readiness Review (RR) onsite survey of the applicant PACE Center, as required. All initial applications and any Service Area Expansion (SAE) application that includes the addition of a new PACE center requires a RR of

the new center. All deficiencies that may be identified during the DHCS Readiness Review onsite survey of the applicant PACE Center must be addressed through a corrective action plan submitted and accepted by DHCS.

Once CMS and/or DHCS have accepted the applicant's RAI response and the Readiness Review onsite survey has been completed by DHCS and the applicant and accepted by CMS, CMS will reinitiate the final 45/90-day clock review cycle. Conclusion of this cycle results in CMS notification to the applicant of final approval or denial.

PACE Growth and Expansion

All PACE growth and expansion falls into one of the below categories:

New PACE Organization – New entity applying to establish a PO

- Entity must identify specific zip codes to be served in one or more counties
- Entity must be able to serve all requested zip codes from PACE Center (subject to 60-minute one way travel time adult day health center (ADHC) requirement)
- Rate development required for each county requested

Existing PO Expansion (Existing County) – PO adding additional zip codes within existing county service area, opening a new PACE Center within existing county service area, or both

- Entity must be able to serve all requested zip codes from PACE Center(s) (subject to 60-minute one way travel time ADHC requirement)
- POs can add zip codes and use Alternative Care Settings (ACS) and Community-based physician waiver as an interim step before building new PACE Center
- Consider rate development/adjustment to account for expansion within the county and account for potential variance and/or changes in utilization
- Zip code only expansions subject to shorter State/CMS review period

Existing PO Expansion (New County) – PO adding zip codes in a new county of operation

- Usually requires a new PACE Center unless the zip codes requested fall within the required radius to be served by existing PACE Center and interdisciplinary team (IDT)
- Requires new rate development

Program Start Date

To align with state budget and rate development processes, all new PO applications and expansion applications requiring new rate development will only be able to begin operations on either January 1 or July 1 of a given year following receipt of final approval from CMS and DHCS. Prospective POs and expansion applicants requiring new rate development should take the available start dates into consideration when preparing to submit an application. Any delays in the application submission or review process may result in the program start getting pushed back to the next available program start date of either January 1 or July 1.

Key Dates for CMS Application Submission

The downloadable PDF of the application and additional information such as application submission deadlines can be found at: https://www.cms.gov/Medicare/Health-Plans/PACE/Downloads/PACE_Application_Training_Feb_2017.pdf.

Initial Application Submission Components

Letter of Intent

All applicants must submit a Letter of Intent (LOI) to DHCS indicating their plans to submit a PACE application. The LOI should identify the applicant; the proposed service area, including a listing of proposed zip codes and a service area map; and the proposed site location for the applicant's PACE center. New applicants proposing to serve an area with an existing or pending PACE plan must identify the overlapping zip codes in their LOI. If an applicant has any questions about whether there is an existing or pending PO operating in its proposed service area it can refer to the DHCS PACE website for a listing of all zip codes by county that POs currently operate in at: http://www.dhcs.ca.gov/individuals/Pages/PACEPlans.aspx. Pending applications for new or expansion POs will also be posted to the DHCS website.

Based on the CMS application submission deadlines, LOI to DHCS would follow the below timeframes:

Letter of Intent to DHCS no later than…	**Initial Application Submission to DHCS no later than…**	**CMS Application Submission Deadlines *last business day of Quarter**
October 1, 2017	November 1, 2017	January 1, 2018
January 1, 2018	February 1, 2018	April 1, 2018
April 1, 2018	May 1, 2018	July 1, 2018
July 1, 2018	August 1, 2018	October 1, 2018

Letters of Support

All PACE applicants must submit letters of support from local entities in the area that the applicant proposes to serve. These may include but are not limited to County Board of Supervisors, County Health and Human Services (HHS) Director, local hospitals, Medi-Cal managed care plans, Independent Physician Associations (IPAs), Commission on Aging, Area Agencies on Aging (AAA), local Multipurpose Senior Services Program (MSSP) Waiver sites, etc. Letters of support should be attached to the LOI. The minimum requirements for letters of support in County Organized Health System counties is provided below.

Market Feasibility Study

All PACE applicants must submit a market analysis of the area that they propose to serve. The feasibility study should include the following:

- Estimate of the number of PACE-eligible individuals
- Description of the methodology/assumptions used to determine potential membership

- Identify all competitive factors impacting the market, such as:
    - Existing POs
    - Managed care plans (MCPs)
    - Demonstration County MCPs (Cal MediConnect and Managed Long-Term Services and Supports (LTSS))
    - Medi-Cal Waiver Programs
    - In-Home Supportive Services (IHSS)
- Identify projected market capture/saturation rates
- Demonstrate that there is an unmet need for PACE in the proposed service area
    - Please note that when multiple applications are received for the same county/zip code service area the order of submission and number of pre-existing plans may have an impact on the decision to approve / deny an application.

Application Narrative

The following PACE application sections must be submitted to DHCS for initial review (see Attachment 1):

New PACE Application	Service Area Expansion (Existing and New County)
• 3.1 – Service Area • 3.2 – Legal Entity and Organization Structure • 3.3 – Governing Body • 3.4 – Fiscal Soundness	• 3.1 – Service Area • 3.4 – Fiscal Soundness • 3.5 – Marketing • 3.13 – Contracted Services • 3.23 – Transportation Services

In addition to the attestations and documents required in the PACE application, DHCS requires detailed narrative in each of these sections to better understand the organizational background and financial standing of the applicant.

Additional Considerations and Limitations

Overlapping service area

New applicants proposing to enter an area already served by an existing PO must identify the overlapping zip codes in their LOI. DHCS will immediately notify any existing and/or pending POs of the new applicant's intent, and the existing and/or pending PO(s) will have an opportunity to submit their own market analysis in response. The counter-analysis must be submitted to DHCS by the initial application submission date. Overlapping service areas are determined at the zip code level. Therefore, if a PO is only servicing a portion of a county and a new or expansion application is requesting a zip code not in the POs service area, by zip code, then the new or expansion application would not trigger notification to the existing/pending PO for an overlapping service area competing market analysis.

DHCS will conduct its own analysis using Medi-Cal data to verify the market feasibility studies that applicants/POs submit. DHCS will evaluate actual numbers of Medi-Cal beneficiaries by age and aid code and will use historical trends of clinical eligibility and market capture to compare against market analyses submitted by applicants/existing POs.

DHCS, in consultation with other State Administering Agencies, has developed a review tool to assist in considering prospective PO applications and the overlapping service area they propose to enter. The review tool is included as Attachment II (Service Area Overlap Review Criteria) to this letter. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Restrictions on Delegation

DHCS is using this PACE Policy Letter to provide explicit clarification to its policy on the use of delegation in the PACE model. DHCS prohibits existing and applicant POs from delegating a separate entity to operate existing and/or additional (expansion) PACE Centers and IDTs. POs are responsible for coordinating and delivering the medical and long term care of frail and vulnerable elderly Californians so that they can remain living safely in their community rather than receiving institutional care. Because of the complexity of this responsibility, the Department has serious concerns with arrangements to delegate the administration of a PACE Center or PACE IDT to third parties. DHCS intends to amend its PACE contracts to include this prohibition. The validity of the DHCS concerns regarding delegation in the PACE model are reflected in the Responses of CMS to Comments presented in the Federal Register, Volume 71, No. 236, pages 71247 to 71263, and 71270 to 71272, regarding Title 42, Code of Federal Regulations, parts 460.60, 460.70, and 460.71.

There is one existing delegated delivery model within PACE in California. The On Lok delegation contract with the Institute of Aging was originally established on August 1, 1996. This model was identified as a contractual arrangement in place on or before July 1, 2000, and was confirmed as “grandfathered” in by CMS in a January 15, 2002, letter. Grandfathering was necessary as the arrangement was not explicitly allowed under the PACE permanent provider regulations at that time.

While DHCS explicitly prohibits full delegation of the fundamental program elements of operation of the PACE Center and IDT, POs have the ability to subcontract for any service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a participant in their home/community are accessible by the PO. POs may enter into subcontracting agreements using the PACE Subcontract Boilerplate template provided by DHCS. Any amendments to the boilerplate template require the Department’s prior written approval.

Please note that DHCS’ prohibition on the use of delegation in PACE does not impact POs option to utilize alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the participant’s home, an inpatient facility, or PACE Center. A PACE participant receives some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center and all PACE participants receiving services at an ACS must be assigned to a PACE Center and IDT.

POs in County Organized Health System Counties

Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county. Specifically, Welfare & Institutions code §14087.5 et seq. provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services in those counties. DHCS will only consider the operation of a

third party PO in a COHS county if the applicant includes a COHS' letter of support that includes the following:

- The COHS's support for the establishment of the independent PO in the county, and;
- The COHS request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county.

The COHS letter of support should be included with the LOI submitted by the applicant organization signifying its intent to expand into a COHS county or to start a new PO in a COHS county. DHCS will ultimately decide whether to move forward with a PACE applicant in a COHS and recommend an 1115 Waiver amendment. Any recommendation from DHCS will be subject to CMS review and approval. In the instance that independent operation of a third party PO is approved, the third party PO must contract directly with the State (DHCS) and CMS as the PACE entity in the three-way program agreement. It is not acceptable for the COHS to contract with DHCS and CMS as the PACE entity in the three-way program agreement and delegate operation of the PO to a separate entity.

This policy reflects the process that was utilized to approve the operation of Redwood Coast PACE in Humboldt County. Redwood Coast PACE was approved to operate independently from the COHS because its PACE application was submitted and accepted prior to the launch of the rural Medi-Cal managed care expansion. The COHS (Partnership Health Plan) endorsed the Redwood Coast PACE application and the exception was made possible by an amendment to California's existing 1115(a)(1) Bridge to Reform Demonstration Waiver.

Licensing

PACE Centers must maintain both a Primary Care Clinic License and an ADHC License. POs must also choose to either maintain a Home Health Agency (HHA) License or contract with a licensed HHA for home health services. Assembly bills 847 (Chapter 315 of 2005) and 577 (Chapter 456 of 2009) established the authority for CDPH/DHCS to authorize exemptions to a PO from licensing and regulatory requirements applicable to clinics, adult day health care services, and home health agencies. If requesting exemption from licensure, a PO must maintain at least one of the PACE Center required licenses (Clinic or ADHC) for each PACE Center. Applicants should consult with the California Department of Public Health (CDPH) to verify licensing requirements. CMS will not accept State Readiness Review until all required licenses are secured. Licensure applications can be found at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/ApplyForLicensure.aspx .

Replacement PACE Centers

Existing POs may move locations or consolidate PACE Center sites by constructing a replacement PACE Center. This scenario is distinct from the construction of a new PACE Center, which requires the submission of a service area expansion application. Replacement Centers require the following transition planning items:

- Administrative Notifications: Notify CMS and DHCS at least 120 days prior to projected transition date.
- Transition Plan: PO's must submit a detailed transition plan that outlines the occupancy timeline, replacement center capacity, contingency planning, transportation plan,

notification to participants, and details of any changes in staffing, policies and procedures, etc.

POs seeking to replace its PACE Center(s) should refer to CMS guidance released on October 21, 2016 that provides further detail on the requirements for transition.

If you have any questions regarding the requirements of this Policy Letter, please contact your Integrated Systems of Care contract manager.

Sincerely,

Jacey Cooper, Acting Division Chief
Integrated System of Care Division

Enclosures

Attachment 1
Attachment 2

Attachment I - PACE Application Required Attestations and Uploads

Attestation Topic	Section #	Initial	SAE	Upload Required (Initial)	Upload Required (SAE)
Service Area	3.1	X	X	X	X
Legal Entity and Organizational	3.2	X		X	
Governing Body	3.3	X		X	
Fiscal Soundness	3.4	X	X	X	X
Marketing	3.5	X	X	X	X
Explanation of Rights	3.6	X		X	
Grievance	3.7	X		X	
Appeals	3.8	X		X	
Enrollment	3.9	X		X	
Disenrollment	3.10	X		X	
Personnel Compliance	3.11	X			
Program Integrity	3.12	X			
Contracted Services	3.13	X	X		
Required Services	3.14	X			
Service Delivery	3.15	X			
Infection Control	3.16	X			
Interdisciplinary Team	3.17	X			
Participant Assessment	3.18	X			
Plan of Care	3.19	X			
Restraints	3.20	X			
Physical Environment	3.21	X			
Emergency and Disaster Preparedness	3.22	X			
Transportation Services	3.23	X	X		
Dietary Services	3.24	X			
Termination	3.25	X		X	
Maintenance of Records & Reporting	3.26	X			
Medical Records	3.27	X			
Quality Assessment Performance Improvement	3.28	X		X	
State Attestations	3.29	X		X	X
Waivers	3.30	X		X (as applicable)	
Application Attestations	3.31	X	X	X	X
State Readiness Review	3.32	X	X (as applicable)	X	X (as applicable)

Attachment II: Service Area Overlap Review Criteria

This tool identifies criteria that DHCS will take into consideration when evaluating applications requesting overlap of existing PACE service areas. DHCS is not limited to the use of only this criteria and will take under consideration additional factors as it determines appropriate to fully assess the application. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Category	Subcategory	Criteria
Service Area Overlap with Existing PACE Operator	Service Area Overlap	Overlap includes less than 25% of potential participants in existing service area
		Overlap includes between 25% and 50% of potential participants in existing service area
		Overlap includes between 50% and 75% of potential participants in existing service area
		Overlap includes over 75% of potential participants in existing service area
	Facility Overlap	Proposed service area includes existing PACE facility or alternative care setting
		Proposed service area does not include existing PACE facility or alternative care setting
Level of Success & Investment of Existing PACE Operators/ Applicants	Market Penetration of Existing Operators in Proposed Service Area	Market penetration under 10%
		Market penetration between 10% and 30%
		Market penetration over 30%
	Recent Investments by Existing PACE Operator(s) and Recent Applicant(s) in Proposed Service Area	Facility investment over $5M in the past year
		Facility investment over $5M between 1 and 2 years
		Facility investment over $5M between 2 and 3 years
		No facility investments over $5M in last 3 years
Local Support	Local Government Support	Formal vote of city council or comparable body in support of new applicant
		Letter of support from city council member or comparable official
		No written support from local government official
	Local Service Provider Involvement	Lead applicant is a services provider in proposed service area
		Supporting applicant is a services provider in proposed service area
		No part of applying entity is services provider in proposed service area

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Date: August 17, 2018

Policy Letter 18-01
Supersedes PACE Policy Letter 17-03

To: Program for All-Inclusive Care for the Elderly (PACE) Organizations

Subject: PACE Application Process

Purpose

The purpose of this Policy Letter is to inform Program of All-Inclusive Care for the Elderly (PACE) Organizations (POs) and potential applicant organizations of the updated Department of Health Care Services (DHCS) application review process and timeline for new PO applications and PACE Expansion applications.

Background

In 2016, the California Legislature passed the PACE Modernization Act Trailer Bill (Sections 31-36 of SB 833, Chapter 30, Statutes of 2016) including updates to the payment and regulatory structure of PACE. The updated California PACE statutes, in part, removed the cap on the number of POs that could operate in the state, and allowed for-profit entities to become POs. As a result, DHCS has seen renewed interest in PACE and an increase in new/expansion applications submitted to DHCS for review. Therefore, DHCS is issuing revised guidance to clarify the Department's expectations with respect to the competitive nature of the review process.

The Centers for Medicare & Medicaid Services (CMS) releases annual updates to its PACE Application Guidance to address its electronic PACE application submission timelines, requirements, and review process. Applicants should review this guidance and be aware of CMS requirements for accessing HPMS. The downloadable PDF of the application and additional information can be found at:
https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html

State Application Review Process

All new and expansion PACE applications must go through an initial review process by DHCS in order to move forward with submission to CMS via HPMS. The initial submission components are detailed in this letter, which aims to provide DHCS with key organizational background and financial viability documentation. This information is

Integrated Systems of Care Division
1501 Capitol Avenue, MS 4502
Sacramento, CA 95899-7437
(916) 552-9105
Internet Address: http://www.DHCS.ca.gov

necessary for the State to complete/sign the State Assurance pages and authorize the submission of the full application to DHCS and CMS via HPMS.
Upon submission of the full application to CMS, the State will align its review of the remaining application with the CMS initial 45/90-day clock cycle, dependent on type of application, to create a concurrent review process. The initial CMS 45/90-day clock review begins upon receipt of the completed full application in HPMS, which must include the signed State Assurance pages.

DHCS will review the application according to state and federal laws and regulations. Prior to entering into a contract for the provision of Medi-Cal managed health care services, DHCS may consider any factor it determines to be necessary for consideration (Welfare & Institutions Code §§ 14095 and 14592(b)). This includes considering any information relevant to the issue of whether the application could result in unnecessary duplication of services or impair the financial or service viability of an existing program (42 USCA § 1395eee(e)(2)(B)).

Initial State Review

All new and expansion applications received by DHCS will follow the below initial state review timeframes for application submission:

Action	**Due Date**	**Documents for Submission**	**Reviewer**	**Review Timeframe**
Notification of Intent to DHCS	30 days prior to Initial Application Submission to DHCS	• Letter of Intent • Letter for Support from COHS (if applicable)	DHCS	N/A
Initial Application Submission to DHCS	60 days prior to CMS application submission deadline	• Market Feasibility Study • Letters of Support • Application sections (see Attachment 1)	DHCS	60 Calendar Days
Full Application Submission in HPMS	Align with CMS PACE Application Submission Deadline	• Remaining application sections • State Assurance Page	DHCS/CMS	Align with CMS 45/90 day review clock

Concurrent Federal and State Review

The CMS review process of the PACE Application will include a series of attestations and uploads based on the type of application received, (Initial Application or Service Area Expansion).

Upon completion of the initial CMS 45/90-day clock review of the full application, CMS and/or DHCS may issue a Request for Additional Information (RAI) to the applicant. In the event a RAI is issued, the application is taken off the review clock during this period while the applicant responds to either the CMS and/or DHCS RAI. DHCS will align its remaining review and RAI (if necessary) with CMS timelines and ensure that any necessary changes are communicated to CMS. It is also during this period that DHCS conducts the Readiness Review (RR) onsite survey of the applicant PACE Center, as required. All initial applications and any Service Area Expansion (SAE) application that includes the addition of a new PACE center requires a RR of the new center. All deficiencies that may be identified during the DHCS Readiness Review onsite survey of the applicant PACE Center must be addressed through a corrective action plan submitted and accepted by DHCS.

Once CMS and/or DHCS have accepted the applicant's RAI response and the Readiness Review onsite survey has been completed by DHCS and the applicant and accepted by CMS, CMS will reinitiate the final 45/90-day clock review cycle. Conclusion of this cycle results in CMS notification to the applicant of final approval or denial.

PACE Growth and Expansion

All PACE growth and expansion falls into one of the below categories:

New PACE Organization – New entity applying to establish a PO

- Entity must identify specific zip codes to be served in one or more counties
- Entity must be able to serve all requested zip codes from PACE Center (subject to 60-minute one way travel time adult day health center (ADHC) requirement)
- Rate development required for each county requested

Existing PO Expansion (Existing County) – PO adding additional zip codes within existing county service area, opening a new PACE Center within existing county service area, or both

- Entity must be able to serve all requested zip codes from PACE Center(s) (subject to 60-minute one way travel time ADHC requirement)
- POs can add zip codes and use Alternative Care Settings (ACS) and Community-based physician waiver as an interim step before building new PACE Center
- Consider rate development/adjustment to account for expansion within the county and account for potential variance and/or changes in utilization
- Zip code only expansions subject to shorter CMS review period

Existing PO Expansion (New County) – PO adding zip codes in a new county of operation

- Usually requires a new PACE Center unless the zip codes requested fall within the required radius to be served by existing PACE Center and interdisciplinary team (IDT)
- Requires new rate development

Program Start Date

To align with state budget and rate development processes, all new PO applications and expansion applications requiring new rate development will only be able to begin operations on either January 1 or July 1 of a given year following receipt of final approval from CMS and DHCS. Prospective POs and expansion applicants requiring new rate development should take the available start dates into consideration when preparing to submit an application. Any delays in the application submission or review process may result in the program start getting pushed back to the next available program start date of either January 1 or July 1.

Initial Application Submission Components

Letter of Intent

All applicants must submit a Letter of Intent (LOI) to DHCS indicating their plans to submit a PACE application. The LOI should identify the applicant; the proposed service area, including a listing of proposed zip codes and a service area map; and the proposed site location for the applicant's PACE center. New applicants proposing to serve an area with an existing or pending PACE plan must identify the overlapping zip codes in their LOI. If an applicant has any questions about whether there is an existing or pending PO operating in its proposed service area it can refer to the DHCS PACE website for a listing of all zip codes by county that POs currently operate in at: http://www.dhcs.ca.gov/individuals/Pages/PACEPlans.aspx. Pending applications for new or expansion POs will also be posted to the DHCS website.

CMS application submission deadlines can be found under the application training guide here: https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html. The LOI to DHCS must be submitted at least 90 days prior to the proposed CMS submission date and the initial application must be submitted at least 60 days prior to the proposed CMS submission date.

Letters of Support

All PACE applicants must submit letters of support from local entities in the area that the applicant proposes to serve. These may include but are not limited to County Board of Supervisors, County Health and Human Services (HHS) Director, local hospitals, Medi-

Cal managed care plans, Independent Physician Associations (IPAs), Commission on Aging, Area Agencies on Aging (AAA), local Multipurpose Senior Services Program (MSSP) Waiver sites, etc. Letters of support should be attached to the LOI. The minimum requirements for letters of support in County Organized Health System counties is provided below.

Market Feasibility Study

All PACE applicants must submit a market analysis of the area that they propose to serve. The feasibility study should include the following:

- Estimate of the number of PACE-eligible individuals
- Description of the methodology/assumptions used to determine potential membership
- Identify all competitive factors impacting the market, such as:
    - Existing POs
    - Managed care plans (MCPs)
    - Demonstration County MCPs (Cal MediConnect and Managed Long-Term Services and Supports (LTSS))
    - Medi-Cal Waiver Programs
    - In-Home Supportive Services (IHSS)
- Identify projected market capture/saturation rates
- Demonstrate that there is an unmet need for PACE in the proposed service area
    - Please note that when multiple applications are received for the same county/zip code service area the order of submission and number of pre-existing plans may have an impact on the decision to approve / deny an application.

State Application Narrative

The following PACE application sections must be submitted to DHCS for initial review (see Attachment 1):

New PACE Application	Service Area Expansion (Existing and New County)
• 3.1 – Service Area • 3.2 – Legal Entity and Organization Structure • 3.3 – Governing Body • 3.4 – Fiscal Soundness	• 3.1 – Service Area • 3.4 – Fiscal Soundness • 3.5 – Marketing • 3.13 – Contracted Services • 3.23 – Transportation Services

In addition to the attestations and documents required in the PACE application, DHCS requires detailed narrative in each of these sections to better understand the organizational background and financial standing of the applicant.

Additional Considerations and Limitations

Overlapping service area

New applicants proposing to enter an area already served by an existing PO must identify the overlapping zip codes in their LOI. DHCS will immediately notify any existing and/or pending POs of the new applicant's intent, and the existing and/or pending PO(s) will have an opportunity to submit their own market analysis in response. The counter-analysis must be submitted to DHCS by the initial application submission date. Overlapping service areas are determined at the zip code level. Therefore, if a PO is only servicing a portion of a county and a new or expansion application is requesting a zip code not in the POs service area, by zip code, then the new or expansion application would not trigger notification to the existing/pending PO for an overlapping service area competing market analysis.

DHCS will conduct its own analysis using Medi-Cal data to verify the market feasibility studies that applicants/POs submit. DHCS will evaluate actual numbers of Medi-Cal beneficiaries by age and aid code and will use historical trends of clinical eligibility and market capture to compare against market analyses submitted by applicants/existing POs.

DHCS, in consultation with other State Administering Agencies, has developed a review tool to assist in considering prospective PO applications and the overlapping service area they propose to enter. The review tool is included as Attachment II (Service Area Overlap Review Criteria) to this letter. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Restrictions on Delegation

DHCS is using this PACE Policy Letter to provide explicit clarification to its policy on the use of delegation in the PACE model. DHCS prohibits existing and applicant POs from delegating a separate entity to operate existing and/or additional (expansion) PACE Centers and IDTs. POs are responsible for coordinating and delivering the medical and long term care of frail and vulnerable elderly Californians so that they can remain living safely in their community rather than receiving institutional care. Because of the complexity of this responsibility, the Department has serious concerns with arrangements to delegate the administration of a PACE Center or PACE IDT to third parties. DHCS intends to amend its PACE contracts to include this prohibition. The validity of the DHCS concerns regarding delegation in the PACE model are reflected in the Responses of CMS to Comments presented in the Federal Register, Volume 71, No. 236, pages 71247 to 71263, and 71270 to 71272, regarding Title 42, Code of Federal Regulations, parts 460.60, 460.70, and 460.71.

There is one existing delegated delivery model within PACE in California. The On Lok delegation contract with the Institute of Aging was originally established on August 1, 1996. This model was identified as a contractual arrangement in place on or before July 1, 2000, and was confirmed as "grandfathered" in by CMS in a January 15, 2002, letter. Grandfathering was necessary as the arrangement was not explicitly allowed under the PACE permanent provider regulations at that time.

While DHCS explicitly prohibits full delegation of the fundamental program elements of operation of the PACE Center and IDT, POs have the ability to subcontract for any service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a participant in their home/community are accessible by the PO. POs may enter into subcontracting agreements using the PACE Subcontract Boilerplate template provided by DHCS. Any amendments to the boilerplate template require the Department's prior written approval.

Please note that DHCS' prohibition on the use of delegation in PACE does not impact POs option to utilize alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the participant's home, an inpatient facility, or PACE Center. A PACE participant receives some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center and all PACE participants receiving services at an ACS must be assigned to a PACE Center and IDT.

POs in County Organized Health System Counties

Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county. Specifically, Welfare & Institutions code §14087.5 et seq. provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services in those counties. DHCS will only consider the operation of a third party PO in a COHS county if the applicant includes a COHS' letter of support that includes the following:

- The COHS's support for the establishment of the independent PO in the county, and;
- The COHS request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county.

The COHS letter of support should be included with the LOI submitted by the applicant organization signifying its intent to expand into a COHS county or to start a new PO in a COHS county. DHCS will ultimately decide whether to move forward with a PACE applicant in a COHS and recommend an 1115 Waiver amendment. Any recommendation from DHCS will be subject to CMS review and approval. In the instance that independent operation of a third party PO is approved, the third party PO must contract directly with the State (DHCS) and CMS as the PACE entity in the three-way program agreement. It is not acceptable for the COHS to contract with DHCS and CMS as the PACE entity in the three-way program agreement and delegate operation of the PO to a separate entity.

This policy reflects the process that was utilized to approve the operation of Redwood Coast PACE in Humboldt County. Redwood Coast PACE was approved to operate independently from the COHS because its PACE application was submitted and accepted prior to the launch of the rural Medi-Cal managed care expansion. The COHS (Partnership Health Plan) endorsed the Redwood Coast PACE application and the exception was made possible by an amendment to California's existing 1115(a)(1) Bridge to Reform Demonstration Waiver.

Licensing

PACE Centers must maintain both a Primary Care Clinic License and an ADHC License. POs must also choose to either maintain a Home Health Agency (HHA) License or contract with a licensed HHA for home health services. Assembly bills 847 (Chapter 315 of 2005) and 577 (Chapter 456 of 2009) established the authority for CDPH/DHCS to authorize exemptions to a PO from licensing and regulatory requirements applicable to clinics, adult day health care services, and home health agencies. If requesting exemption from licensure, a PO must maintain at least one of the PACE Center required licenses (Clinic or ADHC) for each PACE Center. Applicants should consult with the California Department of Public Health (CDPH) to verify licensing requirements. CMS will not accept State Readiness Review until all required licenses are secured. Licensure applications can be found at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/ApplyForLicensure.aspx .

Replacement PACE Centers

Existing POs may move locations or consolidate PACE Center sites by constructing a replacement PACE Center. This scenario is distinct from the construction of a new PACE Center, which requires the submission of a service area expansion application. Replacement Centers require the following transition planning items:

- Administrative Notifications: Notify CMS and DHCS at least 120 days prior to projected transition date.
- Transition Plan: PO's must submit a detailed transition plan that outlines the occupancy timeline, replacement center capacity, contingency planning, transportation plan, notification to participants, and details of any changes in staffing, policies and procedures, etc.

POs seeking to replace its PACE Center(s) should refer to CMS guidance released on October 21, 2016 that provides further detail on the requirements for transition. Replacement Centers are not subject to the January 1 or July 1 start dates.

If you have any questions regarding the requirements of this Policy Letter, please contact your Integrated Systems of Care contract manager.

Sincerely,

ORIGINAL SIGNED BY

Sarah Eberhardt-Rios, Division Chief
Integrated System of Care Division

Enclosures

Attachment 1
Attachment 2

Attachment I - PACE Application Required Attestations and Uploads

Attestation Topic	Section #	Initial	SAE	Upload Required (Initial)	Upload Required (SAE)
Service Area	3.1	X	X	X	X
Legal Entity and Organizational	3.2	X	X	X	X
Governing Body	3.3	X	X	X	X
Fiscal Soundness	3.4	X	X	X	X
Marketing	3.5	X	X	X	X
Explanation of Rights	3.6	X	X	X	X
Grievance	3.7	X	X	X	X
Appeals	3.8	X	X	X	X
Enrollment	3.9	X	X	X	X
Disenrollment	3.10	X	X	X	X
Personnel Compliance	3.11	X	X		
Program Integrity	3.12	X	X		
Contracted Services	3.13	X	X		
Required Services	3.14	X	X		
Service Delivery	3.15	X	X		
Infection Control	3.16	X	X		
Interdisciplinary Team	3.17	X	X		
Participant Assessment	3.18	X	X		
Plan of Care	3.19	X	X		
Restraints	3.20	X	X		
Physical Environment	3.21	X	X		
Emergency and Disaster	3.22	X	X		
Transportation Services	3.23	X	X		
Dietary Services	3.24	X	X		
Termination	3.25	X	X	X	X
Maintenance of Records &	3.26	X	X		
Medical Records	3.27	X	X		
Quality Assessment Performance Improvement	3.28	X	X	X	X
State Attestations	3.29	X	X	X	X
Waivers	3.30	X	X	X (as applicable)	
Application Attestations	3.31	X	X	X	X
State Readiness Review	3.32	X	X (as applicable)	X	X (as applicable)

Back to Agenda Back to Item

Attachment II: Service Area Overlap Review Criteria

This tool identifies criteria that DHCS will take into consideration when evaluating applications requesting overlap of existing PACE service areas. DHCS is not limited to the use of only this criteria and will take under consideration additional factors as it determines appropriate to fully assess the application. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Category	Subcategory	Criteria
Service Area Overlap with Existing PACE Operator	Service Area Overlap	Overlap includes less than 25% of potential participants in existing service area
		Overlap includes between 25% and 50% of potential participants in existing service area
		Overlap includes between 50% and 75% of potential participants in existing service area
		Overlap includes over 75% of potential participants in existing service area
	Facility Overlap	Proposed service area includes existing PACE facility or alternative care setting
		Proposed service area does not include existing PACE facility or alternative care setting
Level of Success & Investment of Existing PACE Operators/ Applicants	Market Penetration of Existing Operators in Proposed Service Area	Market penetration under 10%
		Market penetration between 10% and 30%
		Market penetration over 30%
	Recent Investments by Existing PACE Operator(s) and Recent Applicant(s) in Proposed Service Area	Facility investment over $5M in the past year
		Facility investment over $5M between 1 and 2 years
		Facility investment over $5M between 2 and 3 years
		No facility investments over $5M in last 3 years
Local Support	Local Government Support	Formal vote of city council or comparable body in support of new applicant
		Letter of support from city council member or comparable official
		No written support from local government official
	Local Service Provider Involvement	Lead applicant is a services provider in proposed service area
		Supporting applicant is a services provider in proposed service area
		No part of applying entity is services provider in proposed service area

Back to Agenda Back to Item

PACE

CalOptima

A Public Agency

Better. Together.

PACE Response to Regulatory Guidance

Board of Directors Meeting

September 6, 2018

Phil Tsunoda, Executive Director, Public Policy and Public Affairs

Current PACE Landscape

- Alternative and new methods of expansion are in line with the national PACE growth initiative, known as PACE 2.0

- CalOptima PACE has a variety of expansion strategies in place
  - Alternative Care Settings
  - Community-based physicians
  - Service area expansion to south Orange County

- DHCS Policy Letters create an opportunity for independent PACE centers to operate in County Organized Health System (COHS) counties

DHCS Policy Letters

- October 2017 and August 2018 letters outline the policies affecting the application review process and timelines, as well as restrictions on delegation

- Of note to CalOptima, the policy letters require a letter of support from the COHS health plan as part of an independent PACE Organization (PO) application

DHCS Policy Letters (Cont.)

"DHCS will only consider the operation of an independent PO in a COHS county if the applicant includes a letter of support from the COHS stating:

- The COHS' support for the establishment of the independent PO in the county
- The COHS' request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county"

Regulatory Approval

- CalOptima's *only role* with regard to an independent PO applying to operate in a COHS county is *at the beginning*, in considering whether to issue a letter of support and associated 1115 Waiver amendment request
- Lengthy application process follows this sequence:
  1) Independent PO requests from COHS a letter of support, which includes the 1115 Waiver amendment request
  2) If letter of support is provided, independent PO submits to DHCS a letter stating its intent to apply to operate a PACE center
  3) DHCS considers whether to submit to CMS the waiver amendment request
  4) If DHCS submits, CMS considers whether to approve the waiver amendment request
  5) If CMS approves the waiver amendment, DHCS evaluates the independent PO application
  6) If DHCS approves the application, CMS evaluates the independent PO application

Process for Consideration of Letter of Support

- CalOptima proposes a fair and objective evaluation process that includes, but is not limited to, certain elements:

- Application timeline window
  - Independent POs may submit letter of support requests during the period of November 1, 2018, to January 31, 2019

- Geographic ZIP code designation
  - Independent POs must include the specific ZIP codes the PO is interested in serving within Orange County

Process for Consideration of Letter of Support (Cont.)

- Threshold Criteria (20%)
  1. Operating experience
  2. Financial soundness
  3. Quality performance
  4. Demographic competence

- Primary Criteria (80%)
  5. Potential impact to CalOptima PACE program

Criterion 1: Operating Experience

- Show a minimum of five years of experience operating a PACE center
- Provide evidence of regulatory audits with no sanctions
- Submit operational policies and procedures
- Obtain reference letters from member advocates, providers and community stakeholders

Criterion 2: Financial Soundness

- Submit financial statements for the three most recent consecutive years
  - Income statements
  - Balance sheets
- Report important financial metrics
  - Liquidity
  - Debt ratio
  - Short-term viability
  - Delinquency
- Obtain third-party risk report via Dunn and Bradstreet where available

Criterion 3: Quality Performance

- Report performance against current CalPACE averages
  - Participants residing in nursing homes
  - Hospital admissions per 1,000
  - Hospital days per 1,000
  - Hospital readmission rate
  - Emergency room visits per 1,000
  - Participant satisfaction rating

Criterion 4: Demographic Competence

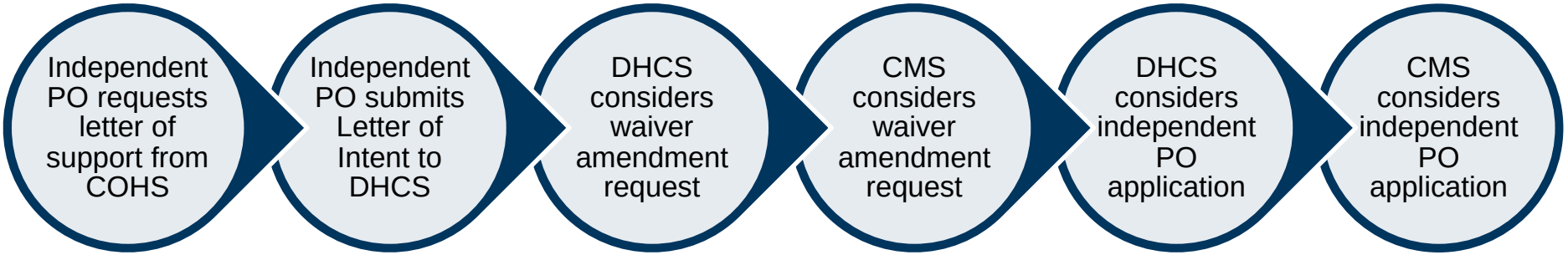
- Provide a general PACE demographic profile of the ZIP code area of interest

- Demonstrate staff experience/understanding in serving PACE participants similar to the potential participants in the geographic area of interest
  - Training in cultural competency
  - Language diversity and capability
  - Accommodations for low literacy
  - Response to socioeconomic factors

Criterion 5: Impact to CalOptima PACE

- State potential impacts of an independent PO on CalOptima's existing PACE program

PACE Application Process



If the application is approved, the independent PO would contract directly with DHCS and CMS

Recommended Actions

- Approve CalOptima PACE expansion strategy in response to state regulatory guidance.

- Authorize the CEO to implement a process to consider letters of support for qualified organizations seeing to establish an independent PACE facility in Orange County.
  - Staff to bring back for Board approval any recommendation regarding a letter of support for an independent PO letter.

A Public Agency

CalOptima

Better. Together.

Enhance PACE Marketing Campaign in a Competitive Service Area

Board of Directors Meeting
November 5, 2020

Elizabeth Lee, Director, PACE Program

Back to Agenda

Back to Item

CalOptima's PACE Program

- Exemplary Outcomes*
  - < 1% of participants reside in long-term care
  - 95% pneumococcal vaccination rate
  - 97% influenza vaccination rate
- State and National Recognition
  - #1 participant satisfaction rating among PACE organizations in California
  - Recognition from the National PACE Association as a "shooting star" and "supernova" for growth and access to PACE
- Steward of Public Funds**
  - Revenue: $42,189,583
  - Medical Costs: $37,731,523 (89.4% ALR)
  - Administrative Costs: $2,002,647 (4.7% MLR)
  - Net Operating Margin: $2,455,414

* PACE 2019 Quality Improvement Plan Evaluation

** Board approved FY 20–21 PACE Operating Budget

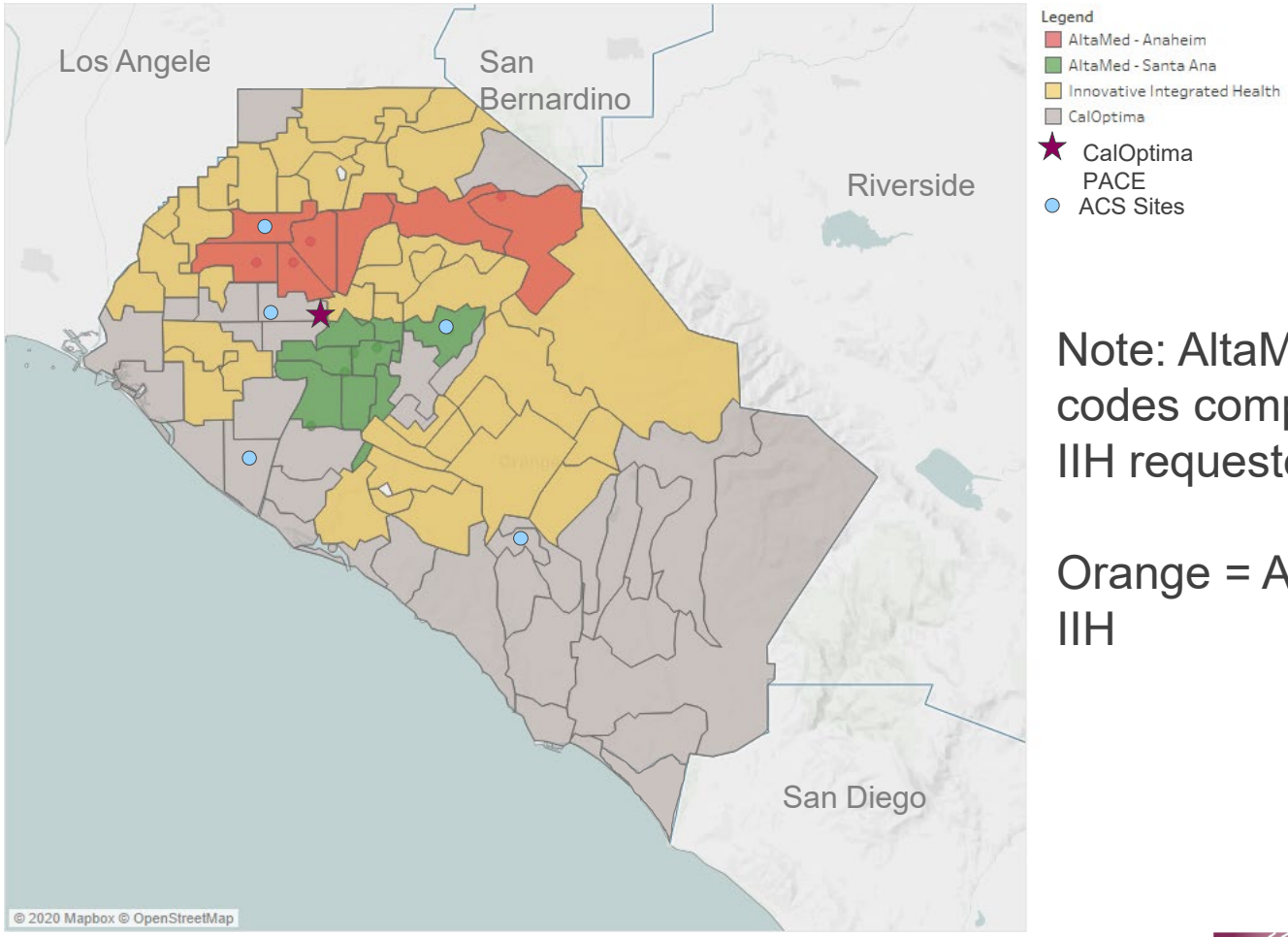
Back to Agenda Back to Item

CalOptima
A Public Agency

Background

- April 2019
  - CalOptima Board of Directors approved two letters supporting the establishment of independent PACE organizations in Orange County
- August 2020
  - DHCS notified CalOptima that CMS approved California's request to amend its Medi-Cal 2020 Section 1115(a) Demonstration Waiver to expand PACE in Orange County
    - AltaMed Health Services application to operate a PACE organization in Orange County was accepted
    - Innovative Integrated Health (IIH) submitted an application to operate PACE in Orange County with no timeline known publicly
  - January 2021
    - Anticipated opening of AltaMed Anaheim PACE site

Overlapping Service Area Map



Note: AltaMed Anaheim ZIP codes completely overlap with IIH requested service area

Orange = AltaMed Anaheim + IIH

Source: CalOptima PACE

Back to Agenda
Back to Item

CalOptima
A Public Agency

Service Area Overlap Analysis

- All 24 ZIP codes included in the AltaMed application and 44 ZIP codes in the IIH application overlap CalOptima's PACE service area.
- National PACE Association projections, based on US Census Data in 2019, estimated the total number of individuals in Orange County who are potentially eligible to enroll in PACE is approximately 6,000.
- Staff recommends elevation of CalOptima PACE brand through increased advertising and direct mail campaign activities to match our market.

Enhanced Marketing and Brand Awareness Campaign

Account	FY 21 Approved Budget	FY21 Enhanced Campaign Recommendation	Justification
Public Activities	$13,000	$8,000	Promotional items to support branding (outreach and retention); Senior Health and Wellness events
Member Communication	$140,000	$45,000	Direct mail, marketing materials, collateral
Advertising	$210,000	$175,000	Print, radio, outdoor, digital and television
	$363,000	**$228,000**	**Total for current budget and enhanced campaign $591,000**

Staff Recommendation

- Authorize unbudgeted expenditures in an amount up to $228,000 from existing reserves to support an enhanced marketing campaign for the remaining months in fiscal year 2020–21

Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

Back to Agenda

Back to Item

CalOptima
A Public Agency

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kenny the Printer	17931 Sky Park Circle	Irvine	CA	92714
Integrated Impressions	23232 Peralta Dr., Ste. 212	Laguna Hill	CA	92653
Vail Dunlap	9371 Irvine Blvd.	Irvine	CA	92618
Sapphire	PO Box 29338	Phoenix	Az	85038
The Dot	2424 McGaw Ave.	Irvine	CA	92614
Image Source	Image Source	Kirkland	WA	98034
Excelsior (OC Register)	PO Box 55210	Colorado Springs	CA	80962
Nguoi Viet (newspaper)	14891 Moran Street	Westminster	CA	92683
Vien Dong (newspaper)	14891 Moran Street	Westminster	CA	92683
Viet Bao (newspaper)	3941 Capri Ave.	Irvine	CA	92606
Seeb Magazine	5250 E. Honeywood Lane	Anaheim	CA	92807
Estrella Media (La Ranchera Radio, Estrella TV)	3101 W 5th Street	Santa Ana	CA	92703
Clear Channel	19320 Harborgate Way	Torrance	CA	90501
Outfront Media	PO Box 33074	Newark	NJ	07188
Spectrum Reach Cable Television	6 Hutton Center, Suite 150	Santa Ana	CA	92707

Back to Agenda Back to Item

Enhanced PACE Marketing Campaign

FY21 Detailed Request

Account Description	Enhancement	FY21 Additional Funds	Justification/Comments	Potential Vendors
Public Activities				
Promotional Items	Membership Retention Year-round presence	$ 5,000.00	To support branded products to include in "PACE Without Walls" care packages to engage participants and eligibile individuals in the community, such as medicine bottle openers, magnitfying glasses, walker bags, socks, wellness and hygiene products. The additional funds being requested will support these efforts through the duration of the fiscal year.	Integrated Impressions Vail Dunlap
Senior Health and Wellness Events	Membership Retention Year-round Presence	$ 3,000.00	To support expenses related (non-food) to drive-thru style and virtual events, until safe to return to in-person Senior Health & Wellness Events. Funds will support four events in FY 2021.	Integrated Impressions Vail Dunlap
	Expense Category Total	**$ 8,000.00**		
Member Communication				
Direct Mail (Prospective Participants)	Increase direct mail Year-round presence	$ 40,000.00	To build on the succes of the direct mail campaign. In FY20, the campaign generated nearly 1,500 leads, which resulted in 80 enrollments (approx. 6.7 enrollments per month). For FY21, the PACE program needs additional support to increase enrollment (goal = net 9 enrollments/month). Also, as the program grows, PACE administration expects higher attrition rates, therefore a constant source of lead generation will be critical to PACE's growth. The goal is to increase mailings from 30,000 households per quarter (FY20) to 40,000 households per quarter (FY21). The existing funds in FY21 budget are not sufficient to cover the costs of conducting the direct mail campaign as planned.	Kenny the Printer Sapphire The Dot Image Source
Marketing Materials (Various)	Update collateral materials	$ 5,000.00	Anticipate costs associated with re-prints of existing materials in FY21. With further expansion of alternative care settings sites, PACE will need additional marketing materials, including partnership fliers and other collateral materials to support their expansion efforts. In addition, a need exists to print special materials in association with the 7th year anniversary milestone.	Kenny the Printer Sapphire The Dot Image Source
	Expense Category Total	**$ 45,000.00**		
Advertising				
Print	Year-Round Presence	$ 25,000.00	Conducted year-round print advertising in English senior directories and Vietnamese community newspapers in FY 20. Advertised quarterly in English and Spanish community newspapers. For FY21, goal is to maintain year-round advertising in English senior directories and Vietnamese newspapers. Request funds to increase presence in English and Spanish community newspapers to year-round. Additionally, request to maintain and expand presence in key target demographic areas (Farsi, southern Orange County, etc.) as the marketing needs of the program change.	Excelsior (OC Register) Nguoi Viet Vien Dong Viet Bao Seeb
Radio	Year-Round Presence	$ 35,000.00	Goal is to maintain year-round radio advertising in Spanish-language radio station. Request to add a Vietnamese radio campaign in the top two most prominent stations for that community (at a minimum of one quarter per station). Current budget allowes for advertising 2 weeks per month in Spanish-language radio. Request for addition funds to increase advertising to 3 weeks per month, equating to 36 weeks of advertising per year. This aligns with the level of year-round advertising conducted in FY20. Staff request additional increase to cover 11 more weeks of advertising (total of 47 weeks per year). In regards to Vietnamese radio advertising, current budget allows for advertising for one month. Staff request funds to cover 3-month campaign for two radio stations.	Seeb Estrella Media (La Ranchera Radio) Vietnames-language radio stationi to be determined
Outdoor	Year-Round Presence	$ 35,000.00	Historically, PACE conducts seasonal advertising in outdoor platforms such as billboards, transit shelters and OCTA buses (exterior and interior ads). Typically, these outdoor campaigns occur between April and June for two months. Staff request additional funds for FY21 to conduct two seasonal outdoor campaigns, each for a duration of 2-3 months to support enrollment goals during the 'slow season' (late fall and winter), as well as provide an opportunity to increase PACE promotion in the community during the time that an independent PACE center enters the service area.	Clear Channel Outfront Media

Back to Agenda

Back to Item

Enhanced PACE Marketing Campaign

FY21 Detailed Request

Account Description	Enhancement	FY21 Additional Funds	Justification/Comments	Potential Vendors
Digital	Year-Round Presence	$ 10,000.00	Tactic added to establish market presence, increase visibility with key audiences and meet standard of independent PACE centers in the overlapping service area. Historically, PACE has conducted seasonal advertising in digital platforms to coordinate with the outdoor advertising campaign. This is done through geotargeted mobile ads that focus in neighborhoods surrounding the PACE center and its ACS sites. As stated in the justification for outdoor advertising, the goal is to conduct two seasonal campaigns. Staff request additional funds to cover the costs of conducting an additional digital (geotargeted mobile ad) campaign to coordinate with the second outdoor campaign. The requested funds will also expand the reach of this campaign to target areas near other PACE locations. In addition to the geotargeted mobile ads, the goal is to substantially increase advertising in digital platforms. Digital advertising provides a unique opportunity to target specific groups of people based on behavior or specific demographics. The messages are delivered directly to target markets and can be measured through CTR (click through rate to CalOptima website/landing page). This type of advertising provides a great deal of flexibility with changing creative (ads) to be responsive and increase engagement with target audiences.	Clear Channel Outfront Media
Television	Marketing standard of PACE in overlapping service area	$ 70,000.00	Independent PACE organizations are establishing a strong presence in the Orange County market with a large volume of television advertisements - one of the top mediums for reaching consumers. Due to cost constraints, PACE has not pursued this tactic. To be at the standard of independent PACE organizations, staff recommend establishing a market presence for PACE in television. Staff recommend engaging a vendor for production of a video to elevate PACE in various ways, such as presentations to partners and prospective members and through CalOptima's website and social media platforms. FY21 budget covers the expense of the video production, yet will not support purchasing television advertisements. Additional funds are requested to create a robust television campaign from January - June 2021 at par with the campaign of independent PACE organizations.	Spectrum, Reach Cable Television Estrella Media
	Expense Category Total	**$ 175,000.00**		
	Grand Total	**$ 228,000.00**		

Back to Agenda

Back to Item

AGENDA ITEM 17

THIS ITEM WILL BE CONSIDERED AFTER CLOSED SESSION

Back to Agenda

Board of Directors Meeting
November 5, 2020

Joint Meeting of the Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee Board Report

---

On October 8, 2020, the Member Advisory Committee (MAC), OneCare Connect Member Advisory Committee (OCC MAC), Provider Advisory Committee (PAC), and Whole-Child Model Family Advisory Committee (WCM FAC) held a joint meeting to discuss topics of mutual interest.

Richard Sanchez, Interim Chief Executive Officer, welcomed the committees and asked Ladan Khamseh, Chief Operating Officer to provide a brief recognition of CalOptima's 25th Anniversary.

Emily Fonda, M.D., Deputy Chief Medical Officer, updated the committees on Medi-Cal Rx, the state's plan to begin administering the Medi-Cal pharmacy benefit directly as of January 1, 2021 rather than continuing to delegate administration of this benefit to the managed care plans. The presentation generated numerous questions and concerns. Committee members emphasized the importance of ensuring that members continue to have access to the medications they need.

Marshall Moncrief, Chief Executive Officer, Mind-OC updated the committees on Be Well OC.

Erin Rueff, O.D., Assistant Professor and Chief of Stein Family Cornea and Contact Lens Center at Marshall B. Ketchum University, provided a presentation on myopic control in children.

The members of the MAC, OCC MAC, PAC, and WCM FAC appreciate the opportunity to update the Board on their current activities and plan to hold another joint meeting on December 10, 2020.

Back to Agenda