NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, OCTOBER 4, 2018
2:00 P.M.

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

BOARD OF DIRECTORS

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

Supervisor Lisa Bartlett, Alternate

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Michael Schrader	Gary Crockett	Suzanne Turf

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

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

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

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report
   a. National Committee for Quality Assurance Recognition
   b. Chief Medical Officer Transition
   c. Whole-Child Model Implementation
   d. Auto-Assignment for CalOptima Community Network
   e. Be Well OC Leadership Role

PUBLIC COMMENTS

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

CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the September 6, 2018 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the May 17, 2018 Meeting of the CalOptima Board of Directors' Finance and Audit Committee, the May 16, 2018 Meeting of the CalOptima Board of Directors' Quality Assurance Committee, the August 9, 2018 Meeting of the CalOptima Board of Directors' Provider Advisory Committee, and the July 12, 2018 Meeting of the CalOptima Board of Directors' Member Advisory Committee

3. Consider Approval of the Updated Strategy for the Disbursement of Years 2-5 OneCare Connect Quality Withhold Payment to CalOptima Community Network

4. Consider Authorizing Modification of Claims Payment Policies Associated with the Implementation of the Whole-Child Model

REPORTS

5. Consider Accepting and Receiving and Filing the Fiscal Year 2018 CalOptima Audited Financial Statements

6. **Acting as the CalOptima Foundation:** Consider Accepting and Receiving and Filing the Fiscal Year 2018 CalOptima Foundation Audited Financial Statements

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

8. Consider Modifications and Development of CalOptima Policies and Procedures Related to Whole-Child Model and Annual Policy Review

9. Consider Authorizing Issuance of a Request for Proposal for Consulting Services to Assist in Analyzing the CalOptima Provider Network Strategy, Approving Related Scope of Work, and Expansion of Existing Engagement with Milliman, Inc. for Actuarial Services

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

11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc. for Pharmacy Benefit Management Services

12. Consider Authorization of Expenditures in Support of CalOptima's Participation in Community Event

13. Consider Chief Counsel Merit Compensation for the 2017-2018 Review Period

ADVISORY COMMITTEE UPDATES

14. Member Advisory Committee Update

15. Provider Advisory Committee Update

INFORMATION ITEMS

16. Intergovernmental Transfer (IGT) Funding Update

17. August 2018 Financial Summary

18. Compliance Report

19. Federal and State Legislative Advocates Report

20. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

NEXT REGULAR MEETING: Thursday, November 1, 2018 at 2:00 p.m.

MEMORANDUM

DATE:	October 4, 2018
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

CalOptima Earns Top Quality Rating in California for an Outstanding Fifth Year
With gratitude and pride, I announce that CalOptima is — for the fifth year in a row — California's top-rated Medi-Cal plan, according to the National Committee for Quality Assurance (NCQA) Medicaid Health Insurance Plan Ratings 2018–2019. CalOptima received a score of 4 out of 5 — the highest score awarded to any Medi-Cal plan in the state. In fact, only 13 Medicaid plans of the 177 reviewed nationwide received higher scores of 4.5 or 5. This five-year achievement would not be possible without your Board's ongoing leadership and guidance. You ensure our focus is on fulfilling our mission for members. Similarly, we cannot succeed without excellent partnerships from the provider community. Daily they deliver the quality care worthy of NCQA recognition. CalOptima's success as a community-based health plan is truly a team effort. Congratulations to all for proving for a fifth time that we remain Better. Together.

Chief Medical Officer (CMO) Transitions to Retirement, Interim CMO Named
I would like to recognize Richard Helmer, M.D., whose last day as CalOptima CMO was September 21. We owe him a debt of gratitude for his excellent leadership not once but three times across CalOptima's history. Most recently, he served as CMO since 2013, but before that, he helped launch the agency in 1995 as a consultant and held an interim CMO position in the late 1990s. Dr. Helmer will be honored at a future Board meeting. But in the meantime, he is off to Europe on his first vacation in retirement! Picking up the medical mantle as Interim CMO is Emily Fonda, M.D. Board certified in internal medicine, Dr. Fonda has been a medical director with CalOptima since 2013, working in the areas of care management, senior programs and long-term support services. She earned her medical degree from University of California, Irvine and holds a master's in Medical Management from University of Southern California.

Whole-Child Model (WCM) Implementation Draws Closer, Readiness Activities Intensify
CalOptima's commitment to ensuring an effective transition of the California Children's Services (CCS) program to the WCM is reflected in our multipronged strategy engaging staff from affected departments as well as community representatives. Please see below for updates about member communications, network operations, advisory committee support and more.

- *Member Notices*: Prior to October 1, the Department of Health Care Services (DHCS) will mail its 90-day notice to more than 13,000 Orange County families, informing them about the upcoming transition of CCS from the Orange County Health Care Agency to CalOptima under the WCM. At that point, CalOptima's Customer Service department anticipates

Back to Agenda

receiving calls. In addition, CalOptima must mail 60- and 30-day notices. We will also be doing up to three automated calls per member, starting 60 days prior to the transition and offering warm transfers to the Customer Service team.

- *Network Certification:* On September 28, CalOptima submitted provider network information to DHCS for approval. At this time, CalOptima and our health networks collectively have contracts with more than 90 percent of the CCS-paneled providers in Orange County. Further, we plan to continue pursuing agreements with CCS-paneled providers who are not currently contracted to raise that percentage even higher. As a backup, we will execute Letters of Agreement with individual noncontracted providers when necessary for continuity of care.
- *Neonatal Intensive Care Unit (NICU) Services Carve-In*: In September, DHCS informed CalOptima that NICU services will be carved in for Orange County under the WCM. Instead of NICU claims being administered at the state level, CalOptima will be responsible for paying the claims. This carve-in was already implemented by health plans that transitioned to WCM in an earlier phase. Your Board will be asked to approve contract amendments to reflect this change.
- *Advisory Committees:* Both families and clinicians are now engaged, and the first meetings of our advisory committees have taken place. On August 9, CalOptima launched the WCM Family Advisory Committee. Seven committee members attended, and the meeting included an update on our implementation efforts as well as an open discussion of topics for future meetings. On September 25, the WCM Clinical Advisory Committee convened for the first time. In addition to CalOptima medical staff, the group includes Hoda Kaddis, M.D., County CCS medical director; Nikta Forghani, M.D., pediatric endocrinologist at CHOC and UCI; John Patrick Cleary, M.D., neonatologist at CHOC; Wyman Lai, M.D., pediatric cardiologist at CHOC; Afshin Aminian, M.D., orthopedic surgeon at CHOC; Amy Harrison, M.D., pediatric pulmonologist at CHOC; Smita Tandon, M.D., pediatrician in private practice; and Michael Weiss, D.O., vice president of CHOC Health Alliance. Unlike the WCM Family Advisory Committee, this clinical group is not required to hold public meetings subject to the Brown Act.
- *Health Network Meetings:* CalOptima has established multiple communication channels via targeted meetings with health network representatives. A biweekly clinical workgroup discusses medical aspects of the program, such as the Medical Therapy Units and custom durable medical equipment. Meanwhile, a different biweekly operations meeting focuses on details like authorizations and transition regulations. A third group gathers project managers from the health networks to ensure a smooth implementation process. Further, a special four-part clinical training session in November and December, presented by Dr. Kaddis, County CCS medical director, will help health networks' frontline medical staff respond effectively to the care coordination needs of members with prevalent CCS conditions in four categories: musculoskeletal and neurologic; cardiovascular; endocrine and metabolic; and respiratory.
- *Family Events:* This month, CalOptima is again offering several opportunities for families with CCS children to attend informational meetings. Held in five locations across Orange County with day and evening times, the events will feature an overview presentation and a question-and-answer segment. Interpreters will also be available to translate as needed.
- *Stakeholder Engagement:* Keeping community-based organizations and other stakeholders up to date about the transition remains a priority. On September 25, the WCM was a featured

topic during the quarterly Community Alliances Forum. And in November, the transition will be the focus of our CalOptima Informational Series meeting.

Joint Advisory Group Meeting to Discuss Auto Assignment
Based on your Board's direction at the September meeting, CalOptima is to gather stakeholder feedback to help guide future action on auto assignment for Medi-Cal members. To that end, auto assignment for the CalOptima Community Network will be a featured topic during the October 11 Joint Meeting of the Provider Advisory Committee, Member Advisory Committee and OneCare Connect Member Advisory Committee. Therefore, the Board item to consider removing the limit on members who can be auto assigned to the CalOptima Community Network is slated to be agendized at your November 1 meeting.

CalOptima Takes on Leadership Role to Build a Better Behavioral Health System
At the September 20 meeting of Be Well OC, a coalition working to improve Orange County's behavioral health system, CalOptima volunteered to be a lead organization, in Be Well parlance, a "backbone" organization. The agency will be responsible for facilitating two of the six results areas: closing treatment gaps and improving access, and developing community wellness hubs. This means we will convene stakeholders to further define the goals in the two areas and then establish a communitywide work plan. Be Well's other four results areas are stigma reduction, prevention and early intervention, strengthening crisis response, and aligning policy/finance/programs.

Back to Agenda

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

September 6, 2018

A Regular Meeting of the CalOptima Board of Directors was held on September 6, 2018, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2:00 p.m. Supervisor Do led the Pledge of Allegiance.

ROLL CALL

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

Members Absent: All Members Present

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Greg Hamblin, Chief Financial Officer; Richard Helmer, M.D., Chief Medical Officer; Ladan Khamseh, Chief Operating Officer; Len Rosignoli, Chief Information Officer; Suzanne Turf, Clerk of the Board

Chair Yost announced the following changes to the agenda: Agenda Item 21, CalOptima Delivery System Overview, will be presented after the Consent Calendar is considered, and Agenda Item 18, Consider Chief Executive Officer and Chief Counsel Performance Reviews and Compensation, to follow closed session.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader reported that CalOptima was awarded National Committee for Quality Assurance (NCQA) accreditation at the commendable level, which will be in effect for three years. Mr. Schrader also reported on the successful completion of the Department of Health Care Services (DHCS) Medi-Cal audit covering the period February 1, 2017 through January 31, 2018. The audit evaluated CalOptima's compliance with our contract and regulations in several areas: utilization management, case management and care coordination, access and availability, member rights and responsibilities, quality improvement system, internal organization and administration, facility site reviews, and medical records review.

PUBLIC COMMENT

1. Nam Si Dong, M.D.; Viet Van Dang, M.D., United Care Medical Group; Toan Q. Tran, M.D., and Trieu Tran, M.D., Family Choice Health Network – Oral re: Agenda Item 5, Consider Changes to the Member Auto-Assignment Limits for the CalOptima Community Network
2. Berenice Constant, AltaMed Health Services – Oral re: Agenda 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

CONSENT CALENDAR

2. Minutes

a. Approve Minutes of the August 2, 2018 Regular Meeting of the CalOptima Board of Directors

b. Receive and File Minutes of the June 28, 2018 Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee, and the June 14, 2018 Meeting of the CalOptima Board of Directors' Provider Advisory Committee

3. Consider Revisions to the Fiscal Year (FY) 2018-19 Board of Directors' Quality Assurance Committee and Board of Directors' Finance and Audit Committee Meeting Schedule

4. **Acting as the CalOptima Foundation:** Consider Appointments to the CalOptima Foundation Audit Committee

Consent Calendar Item 4 was pulled for discussion.

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

4. **Acting as the CalOptima Foundation:** Consider Appointments to the CalOptima Foundation Audit Committee

Director Penrose commented on the CalOptima Foundation, which was formed to receive grant funding from the Office of the National Coordinator to work with Orange County primary care providers to implement electronic health records through the activities of the CalOptima Regional Extension Center (COREC), and the completion of this project several years ago. Mr. Penrose requested that the Board consider the possibility of initiating the process to dissolve the Foundation and directed staff to present options for discussion at a Board future meeting.

Action: ***On motion of Director Penrose, seconded and carried, the Foundation Board of Directors reappointed Lee Penrose and Victor K. Hausmaninger to the CalOptima Foundation Audit Committee for terms ending on September 30, 2020. (Motion carried 9-0-0)***

The agenda was reordered to hear Report Item 21, CalOptima Delivery System Overview.

21. CalOptima Delivery System Overview

Greg Hamblin, Chief Financial Officer, presented an overview of the CalOptima delivery system, including: background on the provider network; comparable health plans; information pertaining to the last CalOptima network Request for Proposal; delivery system metrics; quality and financial metrics; and health network requirements.

Back to Agenda

After considerable discussion of the item, Supervisor Do directed staff to agendize an item for Board consideration at a future meeting to recommend issuing Request for Proposals to conduct a study to analyze CalOptima's provider network strategy, and to seek input from the Member and Provider Advisory Committees ahead of the recommendation to the Board of Directors.

REPORTS

5. Consider Changes to the Member Auto-Assignment Limits for the CalOptima Community Network

Mr. Hamblin presented the recommended action to consider authorizing removal of the 10% auto-assignment limit for the CalOptima Community Network (CCN) and revise Policy EE.1106, Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment to reflect such changes.

After discussion of the matter, the Board of Directors continued this item to the November 1, 2018 Board of Directors meeting in order to solicit input from stakeholders including the Member and Provider Advisory Committees regarding proposed changes to the auto-assignment limit for CCN.

Action: ***On motion of Supervisor Steel, seconded and carried, the Board of Directors continued this item to the November 1, 2018 Board meeting. (Motion carried 9-0-0)***

6. Consider Authorizing Amendment to Medi-Cal Contract with Kaiser Foundation Health Plan, Inc., to Extend Member Enrollment Terms

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

Action: ***On motion of Supervisor Steel, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the contract between Kaiser Foundation Health Plan, Inc. (Kaiser) and CalOptima to continue to provide that new CalOptima Members who are family linked with an existing CalOptima Kaiser Member will be automatically assigned to Kaiser, and new CalOptima Members who had a previous relationship with Kaiser within the last twelve (12) months will be able to choose Kaiser as their CalOptima Health Network. (Motion carried 8-0-0; Director Schoeffel absent)***

7. Consider Ratification of Overpayments to Health Networks Related to the Medi-Cal Component of the OneCare Connect Rates

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

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors ratified overpayments to health networks related to the Medi-Cal component of the OneCare Connect rates for the period of July 1, 2015 through January 31, 2018, in an amount not to exceed $385,000, and made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose. (Motion carried 6-0-0; Supervisors Do and Steel recused; Director Schoeffel absent)***

Back to Agenda

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

Action: ***On motion of Supervisor Steel, seconded and carried, the Board of Directors adopted Resolution No. 18-0906, approving and adopting new Human Resource Policy GA.8059: Attendance and Timekeeping, and updates to Human Resources Policies GA.8027: Unlawful Harassment, GA.8051: Hiring of Relatives, and GA.8058: Salary Schedule. (Motion carried 9-0-0)***

9. Consider Authorizing Employee and Retiree Group Health Insurance for Calendar Year 2019
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 Penrose, seconded and carried, the Board of Directors: 1) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to enter into contracts and/or amendments to existing contracts, as necessary, to continue to provide group health insurance, including medical, dental, vision, for CalOptima employees and retirees (and their dependents), and basic employee life insurance and accidental death and dismemberment, short-term and long-term disability, employee assistance program, and flexible spending accounts for Calendar Year (CY) 2019 in an amount not to exceed $18.5 million; 2) Authorized an increase to CalOptima's contributions to absorb the increase to premium rates of 1.3%, increasing costs to CalOptima in an amount not to exceed $135,375, which will maintain employee contributions at the same dollar amount as CY 2018; 3) Authorized employer contributions in the estimated amount of $161,250 to fully fund Health Savings Accounts on 1/1/2019 for employees or retirees enrolled in the CalOptima Cigna high deductible health plan (HDHP) for CY 2019 in anticipation of eliminating the Cigna PPO plan in CY 2020; 4) Authorized the continuation of a Spousal Surcharge of $50 per pay period (for 24 pay periods) for those employees/retirees whose spouses or Registered Domestic Partners: (a) have access to other medical plans through their own employers or other sources, but choose to be enrolled under the CalOptima plan; or (b) are enrolled in their own medical plan, and elect to also enroll under the CalOptima plan; and 5) Authorized the transition to a 4-tier rate structure for Medical, Dental, and Vision at a cost of approximately $82,874 to allow for identification of enrolled employee spouses and child/children. (Motion carried 8-0-0; Director Schoeffel absent)***

10. Consider Ratification of Amendment to Contract with the California Department of Health Care Services for the California Technical Assistance Program (CTAP) Grant and CTAP Policy; Consider Retirement of CalOptima Regional Extension Center Policies

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors ratified an amendment to the contract with the California Department of Health Care Services for the California Technical Assistance Program (CTAP) grant award agreement for a two-year extension through June 30, 2020, ratified the CTAP policy, and retired CalOptima Regional Extension Center policies. (Motion carried 9-0-0)***

Back to Agenda

11. Consider Modifications and Development of CalOptima Policies and Procedures Related to Whole-Child Model, Medicaid and CHIP Managed Care Final Rule, and Annual Policy Review

Action: ***On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors authorized the Chief Executive Officer to modify existing and develop new policies and procedures in conjunction with the Whole-Child Model initiative, as follows: DD.2006: Enrollment In/ Eligibility with CalOptima [Medi-Cal]; DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment [Medi-Cal]; EE.1112: Health Network Eligible Member Assignment to Primary Care Provider [Medi-Cal]; EE.1132: Bed Day Utilization Criteria for Physician Hospital Consortia [Medi-Cal]; GG.1401: Pharmacy Authorization Process [Medi-Cal]; GG.1409: Drug Formulary Development and Management [Medi-Cal]; GG.1410: Appeal Process for Pharmacy Authorization [Medi-Cal]; GG.1600: Access and Availability Standard [Medi-Cal]; and GG.1650Δ: Credentialing and Recredentialing of Practitioners [All Lines of Business]. (Motion carried 9-0-0)***

12. Consider Approval of Proposed Updated Behavioral Health Policy and Form to Support the Administration of Behavioral Health Treatment Services for Medi-Cal Members

Action: ***On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors approved the updated CalOptima Policy GG.1548: Authorization for Behavioral Health Treatment (BHT) Services. (Motion carried 9-0-0)***

13. Consider Authorization of Expenditure Plan for Intergovernmental Transfer (IGT) 6 and 7 Funds, Including the Release of Requests for Proposals for Community Grants to Address Children's Mental Health, Opioid and Other Substance Overuse, and Other Community Needs Identified by the CalOptima Member Health Needs Assessment

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, presented the recommended actions to: 1) Approve the expenditure plan for allocation of IGT 6 and 7 funds in the amount of $21.1 million for the Department of Health Care Services-approved and Board-approved priority areas; and 2) Authorize the release of Requests for Proposal (RFPs) for community grants and internal project applications, with staff returning at a future Board meeting with evaluation of proposals and recommendations for award(s) being granted.

Director Nguyen acknowledged fellow IGT 6 and 7 Ad Hoc members Supervisor Do and Director Schoeffel and reported that the Ad Hoc recently met to review a pool of 117 Requests for Information responses and recommended the release of six RFPs totaling $21.1 million in remaining IGT 6 and 7 funds. The Ad Hoc also recommended the following revisions to Community Grants: 1) revise the allocation amount for the Access to Outpatient Mental Health Services RFP, Children's Mental Health priority area, from $2.7 million to $4.85 million; 2) revise the allocation amount for Integrate Mental Health Services into Primary Care Settings RFP, Opioid and Other Substance Overuse priority area, from $7 million to $4.85 million; 3) revise the Expand Mobile Food Distribution Services RFP priority area to read, "Community Needs Identified by the MHNA/Childhood Obesity and Children's Health;" 4) revise the Expand Access to Food Distribution Services focused on Children and Families RFP priority area to read, "Community Needs Identified by the MHNA/Childhood Obesity and Children's

Health;" and 5) revise the Expand Access to Food Distribution Services for Older Adults RFP priority area to read, "Community Needs Identified by the MHNA/Older Adult Health."

After discussion of the matter, Chair Yost commented on the importance of focusing on the health care needs of CalOptima members, particularly on nutrition items, and not duplicating services already available in the County from other existing programs such as Meals on Wheels and reduced cost/free school breakfast/lunch programs.

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors approved the expenditure plan for the allocation of IGT 6 an d7 funds in the amount of $21.1 million for the Department of Health Care Services-approved and Board-approved priority areas as revised, and authorized the release of Requests for Proposal for community grants and internal project applications, with staff returning at a future Board meeting with the evaluation of proposals and recommendations for award(s) being granted. (Motion carried 9-0-0)***

14. Consider Ratification of the Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9)

Director Penrose directed staff to provide an analysis of the new regulations pertaining to IGT funding, beginning with IGT 8, to the Board for discussion at a future meeting.

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors ratified and authorized the following activities to secure Medi-Cal funds through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program: 1) Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9); 2) Pursuit of IGT funding partnerships with the University of California-Irvine, the Children and Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach to participate in the upcoming Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9), and; 3) Authorize the Chief Executive Officer to execute agreements with these entities and their designated providers as necessary to seek IGT 9 funds. (Motion carried 9-0-0)***

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

Mr. Tsunoda presented the recommended action to authorize the Chief Executive Officer 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.

After considerable discussion, the Board took the following action.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer 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, with the following revisions: Threshold Criteria revised to 50% weighting; Primary Criteria revised to 50% weighting, and revised to include potential impact on CalOptima PACE program/operations and other PACE Organizations (POs) operating in Orange County, if any. (Motion carried 5-4-0; Vice Chair Khatibi, Supervisors Do and Steel, and Director Schoeffel voting no)

16. Consider Authorization of Expenditures in Support of CalOptima's Participation in Community Events

Action: ***On motion of Supervisor Steel, seconded and carried, the Board of Directors: 1) Authorized the expenditure of up to $10,000 and staff participation at the Vietnamese Cultural Center's 2018 Mid-Autumn Festival on Sunday, September 23, 2018 at Mile Square Park in Fountain Valley, the expenditure of up to $3,000 and staff participation at the Vietnamese Physician Association of Southern California Foundation's Free Health Fair on Sunday, October 14, 2018 at the Westminster Rose Center in Westminster, and the expenditure of up to $1,500 and staff participation at the 2nd Annual Parkinson Interactive Conference for the Latino community on Saturday, October 20, 2018 at Downtown Anaheim Community Center in Anaheim; 2) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and 3) Authorized the Chief Executive Officer to execute agreements as necessary for the events and expenditures. (Motion carried 9-0-0)***

17. Consider Ratification of Contract for Legal Services
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

The motion for ratification of a legal services contract with Richards, Watson and Gerson failed to achieve a majority; no action taken.

18. Consider Chief Executive Officer and Chief Counsel Performance Reviews and Compensation
This item was considered after closed session.

ADVISORY COMMITTEE UPDATES

19. Provider Advisory Committee (PAC) Update
Dr. John Nishimoto, PAC Chair, provided an overview of the topics discussed at their August 9, 2018 meeting, including updates on the Healthcare Effectiveness Data and Information Set (HEDIS) results, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, a review of the Health Homes program, and an update on Intergovernmental Transfer (IGT) 5, 6 and 7 funds.

20. OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee Update
OCC MAC Chair Gio Corzo reported on the activities at their August 23, 2018 meeting, including informational presentations on IGT funding, the Health Homes program, the 2018 HEDIS results, and a review of the CAHPS survey.

Back to Agenda

INFORMATION ITEMS

The following Information Items were accepted as presented:

22. July 2018 Financial Summary
23. Compliance Report
24. Federal and State Legislative Advocates Report
25. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Chair Yost reported on the formation of an ad hoc to review Request for Information responses and making recommendations to the Board of Directors related to the expenditure of Intergovernmental Transfer (IGT) 5 funds, and appointed Supervisor Do, and Directors Nguyen and Penrose to serve with him on this ad hoc.

ADJOURN TO CLOSED SESSION

The Board of Directors adjourned to closed session at 5:58 p.m. pursuant to: 1) Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer); 2) Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS, Agency Designated Representatives: (Paul Yost, M.D. and Lee Penrose) Unrepresented Employee: (Chief Executive Officer); 3) Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Counsel); and 4) Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS, Agency Designated Representatives: (Paul Yost, M.D. and Lee Penrose), Unrepresented Employee: (Chief Counsel).

The Board reconvened to open session at 7:00 p.m. with no reportable actions taken.

18. Consider Chief Executive Officer and Chief Counsel Performance Reviews and Compensation

Chair Yost reported that over the past few months, the Board has met to review the performance of CalOptima's Chief Executive Officer (CEO) and to set goals for Fiscal Year 2018-19 and reported that the Board has completed that process and adopted goals for the CEO for the coming fiscal year. Chair Yost directed the Clerk of the Board to attach the adopted FY 2018-19 goals to the September 6, 2018 Board of Directors Meeting Minutes. Chair Yost also reported that the Board had completed the Chief Counsel's performance review and awarded a score of fully meets expectations for the 2017-2018 review period.

ADJOURNMENT

Chair Yost adjourned the meeting at 7:00 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Attachment: FY 2018-19 CEO Incentive Goals

Approved: October 4, 2018

Back to Agenda

CEO Incentive Goals for FY 2018-19

Board approved on 9-6-2018

Strategic Priority	Goals	Potential Points	Description	Measures of Accomplishment
Innovation Pursue innovative programs and services to optimize member access to care	1. Whole Child Model	25	Complete implementation of Whole Child Model to transition of the California Children's Services (CCS) program from the Orange County Health Care Agency to CalOptima	1. Threshold = Pass State readiness review, followed by successful launch on Jan 1 2. Target = #1 + Risk Stratifications for 100% of CCS children within 45 days of go-live, Health Risk Assessments for 80% of high-risk CCS children by May 31, 2019 3. Exceptional = #2 + Individual Care Plans for 80% of complex CCS children by July 31, 2019
	2. Homeless health	10	Facilitate coordination with the County HCA and Cities to develop a proactive response to dealing with homeless healthcare needs	1. Threshold = Solicit input from community stakeholders such as County Supervisors, HCA, hospitals, etc. 2. Target = Obtain board approval for CalOptima Homeless Initiative 3. Exceptional = Implementation CalOptima Homeless Initiative
	3. Additional PACE Centers in Orange County	10	Evaluate request for letters of support (LOS) from private-sector PACE operators (PO) who want to open Centers in Orange County	1. Target = Board approval for evaluation process 2. Exceptional = Implementation of process
	4. Denti-Cal	10	Explore administration of Denti-Cal in Orange County	1. Threshold = Board approval to pursue Denti-Cal 2. Target = #1 + secure support from California Dental Association and DHCS 3. Exceptional = #2 + secure a legislative sponsor / author
	5. Behavioral Health	10	Expand telemedicine for behavioral health to Community Health Centers (CHC) and FQHCs to increase access and promote integrated care	1. Threshold = Board approval for IGT5 funds to support a pilot 2. Target = Design a pilot program to support telemedicine for behavioral health 3. Exceptional = Implement pilot

Back to Agenda

Strategic Priority	Goals	Potential Points	Description	Measures of Accomplishment
	6. Substance Use Disorders	15	Fully implement a comprehensive pharmacy program to combat opioid abuse that addresses prescribers, retail pharmacies, and members	1. Threshold = Implement by Jan 1, 2019, with a 5% decrease from 1st qtr 2018 to 1st qtr 2019 in the avg morphine milligram equivalent (MME)/member 2. Target = 7.5% decrease in the avg MME/member 3. Exceptional = 10% decrease in the average MME/member + 5% decrease in the number of members receiving a prescription fill for a benzodiazepine and an opioid analgesic in the same quarter
Value Maximize the value of care for members by ensuring quality in a cost-effective way	7. Value Ratings	10	Obtain NCQA rating of top Medi-Cal managed care plan in California for 5th consecutive year, improve CalOptima overall HEDIS scores, and improve auto assignment (AA) ranking for Community Network (CN)	1. Threshold = Commendable accreditation 2. Target = #1 + Improvement in CalOptima overall HEDIS score 3. Exceptional = #2 + top NCQA ranking in CA + top 3 AA ranking for CN
Financial Strength	8. Consolidated financial performance	10	Meet or exceed financial projections in board-approved fiscal year 18/19 budget related to Administrative Loss Ratio (ALR) on a consolidated basis	Threshold (Budget): ALR <= 4.4% Target: ALR <= 4.0% Exceptional: ALR <= 3.5%

Merit Goals

1. Design and implement strategy for new NCQA Population Health standards by May 2019
2. Maximize the number of providers that complete DHCS enrollment and screening process in advance of the Jan 1, 2019, deadline, in accordance with the new federal Mega Reg
3. Onboard three additional PACE Alternative Care Setting (ACS) satellite sites
4. Wind down or alter the purpose of the CalOptima Foundation
5. Redesign CalOptima website to make it more member centric, usable on smart phones, and reflect a contemporary look and feel
6. Continue to elevate CalOptima's profile via leadership roles for CEO at various local, state, and national organizations
7. Complete Employee Engagement Survey to develop actionable improvements for employee retention and morale.
8. 360 Performance Evaluations for all members of executive team, for the purpose of leadership development

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

May 17, 2018

CALL TO ORDER
Chair Lee Penrose called the meeting to order at 2:04 p.m. Director Schoeffel led the Pledge of Allegiance.

Members Present: Lee Penrose, Chair; Scott Schoeffel, Ron DiLuigi

Members Absent: All members present

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Greg Hamblin, Chief Financial Officer; Richard Helmer, M.D., Chief Medical Officer; Ladan Khamseh, Chief Operating Officer; Len Rosignoli, Chief Information Officer; Suzanne Turf, Clerk of the Board

PUBLIC COMMENT
There were no requests for public comment.

INVESTMENT ADVISORY COMMITTEE UPDATE

1. Treasurer's Report
Mr. Hamblin presented an overview of the Treasurer's Report for the period January 1, 2018 through March 31, 2018. Based on a review by the Board of Directors' Investment Advisory Committee, all investments were compliant with Government Code section 53600 *et seq.*, and with CalOptima's Annual Investment Policy.

CONSENT CALENDAR

2. Approve the Minutes of the February 15, 2018 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the January 22, 2018 Meeting of the CalOptima Board of Directors' Investment Advisory Committee

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

Back to Agenda

REPORTS

3. Consider Recommending Board of Directors' Approval of the CalOptima Fiscal Year 2018-19 Operating Budget

Mr. Hamblin presented the actions to recommend that the Board of Directors approve the CalOptima Fiscal Year (FY) 2018-19 Operating Budget and authorize the expenditure and appropriate the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing. As proposed, the FY 2018-19 Operating Budget assumes an average monthly enrollment of approximately 784,000 members, revenue at approximately $3.5 billion, medical costs of approximately $3.3 billion, operating income of approximately $18.3 million, and a total change in net assets of $23.3 million. A detailed review of the proposed FY 2018-19 Operating Budget by line of business was presented to the Committee for discussion.

After considerable discussion of the matter, the Committee directed staff to refine the administrative allocations between the different lines of business for presentation to the Board of Directors. The Committee also requested additional information at a future Finance and Audit Committee meeting regarding the effectiveness of personal care coordinators on all levels.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended Board of Directors' approval of the CalOptima Fiscal Year (FY) 2018-19 Operating Budget and authorize the expenditure and appropriate the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing. (Motion carried 3-0-0)***

4. Consider Recommending Board of Directors' Approval of the CalOptima Fiscal Year 2018-19 Capital Budget

Mr. Hamblin presented the action to recommend that the Board of Directors approve the CalOptima FY 2018-19 Capital Budget and authorize the expenditure and appropriate the funds for the items listed in Attachment A: Fiscal Year 2018-19 Capital Budget by Project, which shall be procured in accordance with CalOptima policy. The recommended FY 2018-19 Capital Budget of $9.8 million in the following asset types within three asset categories: Information systems, including hardware, software, and professional fees related to implementation, approximately $6.9 million; 505 Building improvements, approximately $2.8 million; and PACE Center, $156,000.

Action: ***On motion of Director DiLuigi, seconded and carried, the Committee recommended Board of Directors' approval of the CalOptima Fiscal Year (FY) 2018-19 Capital Budget and authorize the expenditure and appropriate the funds for the items listed in Attachment A: Fiscal Year 2018-19 Capital Budget by Project, which shall be procured in accordance with CalOptima policy. (Motion carried 3-0-0)***

Back to Agenda

INFORMATION ITEMS

5. 2018 Audit Planning

DeVon Wiens of Moss-Adams LLP presented a review of the scope of services for the annual consolidated financial statement audit for the year ending June 30, 2018 and provided a brief overview of the recent changes in accounting standards. Interim fieldwork is scheduled to begin on May 21, 2018, and final fieldwork will begin on July 23, 2018. The draft audited financial statements will be presented to the Finance and Audit Committee for review at the September 2018 meeting.

6. March 2018 Financial Summary

Mr. Hamblin provided an overview of the balance sheet, Board-Designated Reserves and tangible net equity (TNE) requirement as of March 31, 2018.

7. Proposition 56 Update

Candice Gomez, Executive Director, Program Implementation, presented an update on the California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56), which provides additional payments for certain Medi-Cal related services. The DHCS recently released guidance related to physician service payments that applies to 13 specific procedure codes. Proposition 56 payments have been included in the DHCS capitation to CalOptima since April 30, 2018, and payments are to be passed through to eligible providers for the initial payment within 90 calendar days of receiving capitation from DHCS. It was noted that recommendations related to the methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers will be presented to the Board for consideration at the June meeting.

The following Information Items were accepted as presented:

8. CalOptima Information Systems Security Update
9. Cost Containment Improvements/Initiatives
10. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance
    b. Reinsurance Report
    c. Health Network Financial Report
    d. Purchasing Report

COMMITTEE MEMBER COMMENTS

Committee members thanked staff for their work on the FY 2018-19 Operating and Capital Budgets.

ADJOURNMENT

Hearing no further business, Chair Penrose adjourned the meeting at 4:01 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: September 18, 2018

Back to Agenda

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

May 16, 2018

CALL TO ORDER

Acting Chair Ria Berger called the meeting to order at 3:00 p.m. Director Khatibi led the pledge of Allegiance.

Members Present: Ria Berger, Acting Chair; Dr. Nikan Khatibi; Alexander Nguyen, M.D.

Members Absent: Paul Yost, M.D., Chair

Others Present: Michael Schrader, Chief Executive Officer; Richard Helmer M.D., Chief Medical Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Gary Crockett, Chief Counsel; Diana Hoffman, Deputy Chief Counsel; Ladan Khamseh, Chief Operating Officer; Suzanne Turf, Clerk of the Board

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

1. Approve the Minutes of the February 20, 2018 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

Action: ***On motion of Director Nguyen, seconded and carried, the Committee approved the Minutes of the February 20, 2018 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 3-0-0; Chair Yost absent)***

Acting Chair Berger reordered the agenda to hear Item 5, PACE Member Advisory Committee Update.

Back to Agenda

5. PACE Member Advisory Committee Update

Mallory Vega, PACE Member Advisory Committee (PMAC) Community Representative, reported on the activities at the March 26, 2018 PMAC meeting, including a presentation of the 2017 Participant Satisfaction Survey results. The Committee was also informed of the upcoming changes to the number and type of vehicles used for participant transport, and that those impacted by the change will be notified in advance.

REPORTS

2. Receive and File 2017 Utilization Management Program Evaluation

Action: ***On motion of Director Nguyen, seconded and carried, the Committee received and filed the 2017 Utilization Management Program Evaluation as presented. (Motion carried 3-0-0; Chair Yost absent)***

3. Consider Recommending Board of Directors' Approval of the Methodology for and the Disbursement of Years 2-5 OneCare Connect Quality Withhold Payment of Participating Health Networks

Richard Bock, M.D., Deputy Chief Medical Officer, presented the action to recommend Board of Directors' approval of the methodology for and the disbursement strategy of OneCare Connect demonstration years 2-5 (calendar years 2016-19) quality withhold payment to contracted health networks, including the CalOptima Community Network (CCN).

Dr. Bock reported that the Cal MediConnect quality withhold reduces capitation for both Medi-Cal and Medicare payments to CalOptima by two percent (2%) in Year Two and by three percent (3%) in Years Three, Four, and Five. CalOptima can earn back withheld funds by CalOptima by passing a percentage of defined quality withhold measures prescribed by the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) based on industry standard quality metrics. It was noted that while the CalOptima's health networks do not have full accountability for every measure, there are measures that CalOptima has direct responsibility for, and other measures that have shared responsibility between the delegated health networks and CalOptima. The proposed methodology to distribute earned withhold funds back to contracted health networks was presented to the Committee for discussion.

Action: ***On motion of Director Khatibi, seconded and carried, the Committee recommended Board of Directors' approval of the methodology for and the disbursement strategy of OneCare Connect demonstration years 2-5 (calendar years 2016-19) Quality Withhold payment to contracted Health Networks, including CalOptima's Community Network. (Motion carried 3-0-0; Chair Yost absent)***

4. Consider Recommending Board of Directors' Approval of the Modification of the Previously Approved Pay for Value Payment Methodology for Measurement Year (MY) 2017 for CalOptima Community Network (CCN) Providers by Incorporating an Improvement Factor

Dr. Bock presented the action to recommend Board of Directors' approval of the addition of an improvement factor to the MY2017 payment methodology for CCN primary care providers for Medi-Cal, subject to regulatory approval, as applicable. As proposed, the addition of an improvement

factor for the CCN Pay for Value (P4V) program aligns the health network and CCN P4V programs. This alignment will leverage improvement efforts and efficiencies that CCN implements in conjunction with the other Health Networks. A review of the incentive payment methodology was provided to the Committee.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors' approval of the addition of an improvement factor to the MY2017 payment methodology for CCN primary care providers for Medi-Cal, subject to regulatory approval, as applicable. (Motion carried 3-0-0; Chair Yost absent)***

INFORMATION ITEMS

6. PACE Primary Care Physician Incentive Program Update

Miles Masatsugu, M.D., PACE Clinic Medical Director, presented an overview of the proposed modifications to the PACE Primary Care Physician (PCP) Incentive program, including: allowing all PACE PCPs and community-based physicians to participate in the PACE incentive program; increasing the number of quality improvement (QI) elements to align with other lines of business; increasing the QI incentive from $3 per member per month (PMPM) to $10 PMPM; and change the distribution of utilization management (UM) inpatient cost savings sharing element to support inpatient avoidance strategies, including after-hours telephonic coordination of care, after-hours home visit evaluations, admissions directly to senior nursing facilities for appropriate cases, and emergency room evaluations with observation stays. Dr. Masatsugu reviewed the proposed QI incentive elements and proposed UM incentive for discussion.

7. Perinatal Support Services Update

Dr. Bock provided an update on the Perinatal Support Services (PSS) program. In April 2018, a Request for Information/Request for Proposal process was conducted. Two qualified respondents were identified to provide perinatal support services for CalOptima members. One of the responders bid below the Medi-Cal Comprehensive Perinatal Support Program (CPSP) fee-for-service rates. The other respondent, the current capitated vendor, provides PSS services through home visits. However, this vendor's proposed compensation was significantly higher than what would be reimbursed based on the Medi-Cal CPSP fee-for-service rates. It was reported that staff also reviewed current County PSS providers/vendors and rate data, and confirmed that there are over 250 independent, certified CPSP providers currently serving CalOptima members at the CalOptima Medi-Cal fee-for-service rates. Staff proposed the following recommendations for consideration by the Board of Directors at the June meeting: withdraw the Perinatal Support Services RFP; authorize CalOptima to contract with all willing, qualified PSS providers and vendors at Medi-Cal rates; and authorize the addition of an enhanced care coordination rate to compensate for authorized home visits.

8. Quarterly Reports to the Board of Directors' Quality Assurance Committee

The following Quarterly Reports were accepted as presented:

a. Quality Improvement Committee First Quarter 2018 Update
b. Member Trend Report – Fourth Quarter 2017

Back to Agenda

COMMITTEE MEMBER COMMENTS

Committee members commented on the importance of ensuring member access to quality health care and member satisfaction.

ADJOURNMENT

Hearing no further business, Acting Chair Berger adjourned the meeting at 4:03 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: September 12, 2018

Back to Agenda

MINUTES

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

August 9, 2018

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, August 9, 2018, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Teri Miranti, PAC Vice Chair, called the meeting to order at 8:06 a.m., and Member Caliendo led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Teri Miranti, Vice Chair; Anjan Batra, M.D.; Donald Bruhns; Theodore Caliendo, M.D.; Steve Flood; Jena Jensen; Junie Lazo-Pearson, Ph.D.; Brian Lee, Ph.D.; Craig G. Myers; Pamela Pimentel, R.N.; Jacob Sweidan, M.D.
Members Absent:	John Nishimoto, O.D, Chair; Mary Pham, Pharm.D., CHC; Suzanne Richards, MBA, FACHE
Others Present:	Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Greg Hamblin, Chief Financial Officer, Candice Gomez, Executive Director, Program Implementation; Betsy Ha, Executive Director, Quality Analytics; Tracy Hitzeman, Executive Director, Clinical Operations; Michelle Laughlin, Executive Director, Network Operations; Kelly Rex-Kimmet, Director, Quality Analytics; Cheryl Meronk, Director Strategic Development; Paul Jiang, Manager, Quality Analytics; Cheryl Simmons, Staff to the PAC

On behalf of the PAC, Vice Chair Miranti welcomed new PAC members Junie Lazo Pearson, Ph.D. as the Behavioral Health Representative, and Brian Lee, Ph.D., as the Allied Health Representative.

MINUTES

Approve the Minutes of the June 14, 2018 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Jensen, seconded and carried, the Committee approved the minutes of the June 14, 2018 meeting. (Motion carried 11-0-0; Members Nishimoto, Pham and Richards absent)***

Back to Agenda

PUBLIC COMMENTS

No requests for public comment were received.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, noted that the National Committee for Quality Assurance (NCQA) conducted its tri-annual audit of CalOptima in July. The preliminary report indicates that CalOptima achieved a near perfect score, which will allow CalOptima to extend its accreditation. Mr. Schrader provided an update on the transition of the California Children's Services (CCS) to the Whole-Child Model (WCM) effective January 1, 2019. Vice-Chair Miranti inquired about the Neo-Natal Intensive Care Unit (NICU) rates as they relate to the WCM. Mr. Schrader reported that CalOptima is awaiting a response from the Department of Health Care Services (DHCS), and staff will keep the PAC informed of the progress.

Chief Medical Officer Update

Emily Fonda, M.D., Medical Director, provided an update on PACE expansion on April 1, 2018 to include four additional facilities. Dr. Fonda also reported on the Long-Term Services and Support (LTSS) plan in conjunction with the University of California Irvine (UCI), and thanked Member Flood for his help in developing the LTSS plan that would be instrumental in helping reduce admissions to the hospital. Dr. Fonda also reviewed the Model of Care for the CCS implementation to the WCM. She noted that the WCM Family Advisory Committee will hold their first meeting on August 9, 2018, and staff anticipates having the WCM Clinical Advisory Committee seated by Fall of 2018.

Chief Financial Officer Update

Greg Hamblin, Chief Financial Officer, presented CalOptima's Financial Summary as of June 2018, including a report of the Health Network Enrollment for the month, as well as a summary of CalOptima's financial performance and current reserve levels.

Network Operations Update

Michelle Laughlin, Executive Director, Network Operations, updated the PAC on the re-contracting efforts and noted that 94% of the contracts have been signed and returned to CalOptima. This represents over 8,000 of CalOptima providers. She also discussed the new disclosure of ownership form that is now required by the DHCS. A contract amendment will be sent to capitated providers upon approval by the Board that will include the WCM. Ms. Laughlin also shared that CalOptima has contracted with approximately 90% of the CCS providers.

INFORMATION ITEMS

Vice Chair Miranti reordered the agenda to hear VII.C., Intergovernmental Transfer (IGT) Funds 5, 6 and 7.

Intergovernmental Transfer (IGT) Funds 5, 6 and 7

Cheryl Meronk, Director, Strategic Planning, provided an overview of the approved Intergovernmental Transfer (IGT) Funds for IGT 5, 6 and 7. IGT 5 has $14.4M available for

community grants with eight Requests for Information (RFI) that generated 93 responses. Staff is currently reviewing these responses and will present recommendations regarding the proposals to the Board at the October 2018 Board meeting. CalOptima received an additional $8M of unanticipated funds related to IGT 6 and 7. On August 2, 2018, the Board approved an allocation of $10M in IGT funds from IGT 6 and 7 to the Orange County Health Care Agency for the recuperative care services under the Whole-Person Care pilot program. A recommendation for expenditure plans for the remaining $21.1M will be presented to the Board for consideration in September.

Annual Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Update
Kelly Rex-Kimmet, Director, Quality Analytics, and Paul Jiang, Manager, Quality Analytics, presented the 2018 HEDIS and CAHPS results, and noted that CalOptima improved its performance levels from the previous year.

PAC Member Updates
Vice Chair Miranti reminded the members that the next PAC meeting is scheduled on September 13, 2018 at 8:00 a.m. Vice Chair Miranti also noted that an ad hoc needed to be formed to meet in October to assist with the agenda preparation of the joint Member Advisory Committee (MAC), OneCare Connect Member Advisory Committee (OCC MAC), PAC, and the new Whole-Child Model Family Advisory Committee (WCM FAC); this meeting is scheduled for November 8, 2018. Vice Chair Miranti and Member Pimentel volunteered to serve on the ad hoc with Chair Nishimoto.

ADJOURNMENT
There being no further business before the Committee, Vice Chair Miranti adjourned the meeting at 10:06 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: September 13, 2018

Back to Agenda

MINUTES

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

July 12, 2018

A Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on July 12, 2018, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Sally Molnar called the meeting to order at 2:36 p.m., and Chair Molnar led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Sally Molnar, Chair; Patty Mouton, Vice Chair; Suzanne Butler; Connie Gonzalez; Jaime Muñoz; Christine Tolbert; Diana Cruz-Toro; Luisa Santa; Mallory Vega
Members Absent:	Elizabeth Anderson; Sandy Finestone; Donna Grubaugh; Ilia Rolon; Sr. Mary Therese Sweeney
Others Present:	Ladan Khamseh, Chief Operating Officer; Candice Gomez, Executive Director, Program Implementation; Emily Fonda, MD, Medical Director; Sesha Mudunuri, Executive Director, Operations; Tracy Hitzeman, Executive Director, Clinical Operations; Betsy Ha, Executive Director, Quality Analytics, Ana Aranda, Director, Grievance and Appeals, Arif Shaikh, Director, Government Affairs, Marsha Choo, Manager, QI Initiatives, Belinda Abeyta, Director, Customer Service; Eva Garcia, Customer Service

MINUTES

Approve the Minutes of the May 10, 2018, Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

Action: ***On motion of Member Christine Tolbert, seconded and carried, the MAC approved the minutes as submitted.***

PUBLIC COMMENT
There were no requests for Public Comment.

REPORTS

Consider Approval of Updating Fiscal Year (FY) 2018-2019 MAC Goals & Objectives
Member Patty Mouton reported on the MAC Goals & Objectives Ad Hoc Subcommittee composed of MAC members Sally Molnar, Ilia Rolon and Patty Mouton. At the May 10, 2018 MAC meeting, Member Tolbert requested clarification on Partnership and Engagement section of MAC's Goals & Objectives as it relates to measurable outcomes. The MAC Goal & Objectives Ad Hoc Subcommittee reconvened on June 7, 2018 and June 21, 2018 to discuss adding measurable

outcomes. The ad hoc recommended updating the FY2018-2019 Goals & Objectives item III, Partnership and Engagement, to include the following: Convene a MAC Ad Hoc Subcommittee to partner with CalOptima staff to review the Member Health Needs Assessment (MHNA) and provide input and recommendations that will assist in addressing the MHNA findings.

Action: ***On motion of Committee Member Suzanne Butler, seconded and carried, the MAC approved the Updated Fiscal Year (FY) MAC FY 2018-2019 Goals & Objectives. (Motion carried 9-0; Members Anderson, Finestone, Grubaugh, Rolon, and Sweeney absent)***

Consider Recommendation of MAC Candidate

Member Vega reported on the Nominations Ad Hoc Subcommittee, composed of MAC members Suzanne Butler, Sandy Finestone and Mallory Vega, which met on June 5, 2018 to evaluate the application for the vacant Consumer representative seat for FY 2018-2019. The Nominations Ad Hoc recommended Jacque Ruddy for the Consumer representative seat for a term ending June 30, 2020. The recommendation will be presented to the Board of Directors on June 7, 2018 for consideration.

Action: ***On motion of Member Patty Mouton, seconded and carried, the MAC recommended Board of Directors' consider the appointment of Jacque Ruddy to the Consumer Representative seat for a term ending June 30, 2020. (Motion carried 9-0; Members Anderson, Finestone, Grubaugh, Rolon, and Sweeney absent)***

Consider Recommendation of Whole-Child Model Family Advisory Committee (WCM FAC) Slate of Candidates

Member Tolbert reported that the Whole-Child Model Family Advisory Committee (WCM FAC) Ad Hoc Subcommittee, composed of MAC members Connie Gonzalez, Jaime Munoz and Christine Tolbert, reconvened on July 11, 2018 to review the proposed slate of candidates for four voting seats representing the Community representatives that will establish the new WCM FAC. After reviewing the applications and selecting a candidate for each seat, the Nominations Ad Hoc recommended the following Community Representative appointments: Michael Arnot and Diane Key for a two-year term ending June 30, 2020; and Pamela Austin and Sandra Cortez-Schultz to serve for a one-year term ending June 30, 2019. The recommended candidates will be presented to the Board of Directors on June 7, 2018 for consideration.

Action: ***On motion of Member Mallory Vega, seconded and carried, MAC recommended Board of Directors' consider the appointment of Michael Arnot, Pamela Austin, Sandra Cortez-Schultz and Diane Key as the WCM FAC Community Representatives as presented. (Motion carried 9-0; Members Anderson, Finestone, Grubaugh, Rolon, and Sweeney absent)***

Back to Agenda

CEO AND MANAGEMENT REPORTS

Chief Medical Officer Update

Dr. Emily Fonda, Medical Director, presented an overview of the Whole-Child Model (WCM) program that will be effective January 1, 2019, within 21 counties and five health plans. The Whole-Child Model will incorporate California Children's Services (CCS) into Medi-Cal Managed Care. Next steps are to continue meeting with Orange County Health Care Agencies and Health Networks on transition, developing WCM policies, internal workflows, contracting with CCS panel physicians, establishing two advisory groups, and holding stake holder events within the community.

Chief Operating Officer (COO) Update

Ladan Khamseh, COO, provided an update on the transition of members with a non-autism spectrum disorder receiving behavioral health services at the Regional Center of Orange County (RCOC) and are scheduled to transition to CalOptima beginning July 1, 2018. CalOptima will be completing the transition in stages with the first stage occurring July 1, 2018, second stage will be August 1, 2018, and the final transition to occur October 1, 2018. Impacted members will receive 60 and 30-day notices advising them of the transition and to call CalOptima with any questions or concerns.

Federal and State Legislative Update

Arif Shaikh, Director, Public Affairs, provided an update on the state budget.
Not all legislative items in the proposed budget were approved, which directly impacts CalOptima and our membership, including approximately $26 million to streamline Medi-Cal eligibility for the Women's Infants and Children (WIC) program; the expansion of Medi-Cal for low-income seniors; alignment with federal policy for transitional Medi-Cal under the CalWorks program and Welfare to Work Program; and $250 million to extend Medi-Cal to the undocumented population. Mr. Shaikh also reported on trailer bills that CalOptima is following this year, including Proposition 56 supplemental payments from the tobacco tax initiative, and trailer bill 340b related to drug pricing and duplicate discounts.

INFORMATION ITEMS

MAC Member Updates

Chair Molnar introduced two new Committee members: Children's Representative Luisa Santa, and Diana Cruz-Toro, Recipients of CalWORKS Representative. Chair Molnar announced that the MAC and Provider Advisory Committee (PAC) will hold a joint meeting on November 8, 2018 and requested volunteers to serve on an ad hoc to work with the PAC to develop the joint meeting agenda. Vice Chair Mouton and Member Tolbert volunteered to serve on this ad hoc with Chair Molnar. Additionally, it was announced that Vice Chair Mouton will join Chair Molnar on the Goals and Objectives Ad Hoc to review the medical health needs assessments.

Chair Molnar requested volunteers to present at the September 13, 2018 MAC meeting. Member Santa volunteered to present on MOMS Orange County.

Back to Agenda

Update on Palliative Care

Tracy Hitzeman, Executive Director, Clinical Operations, provided an update on Senate Bill 1004, which requires the DHCS to establish standards and provide technical assistance to ensure delivery of palliative care services by Managed Care Plans for members of any age. In response to the Senate Bill, the DHCS released an All-Plan letter updating palliative care guidelines that were effective January 1, 2018 and identified eligibility criteria for this initiative which focuses on four general categories: cancer, chronic obstructive pulmonary disease, congestive heart failure and liver disease. Palliative care will be coordinated by the health networks with oversight by CalOptima. Next steps include community education events, provider education, and additional staff training.

Member Mouton requested additional information on the number of referrals to palliative care compared to the number of referrals to hospice and the length of time a member receives palliative care services.

Access to Care Overview

Marsha Choo, Manager, Quality Improvement Initiatives, provided an overview on Access to Care. CalOptima's Access and Availability subcommittee reviews network adequacy and timely access survey. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) reviews out of network requests, and grievance and appeals. DHCS requires a network adequacy certification, and CalOptima has passed the required certification. Next steps include: educating providers on timely access standards; continuing to recruit and contract with in-demand specialists, particularly in South County; provider coaching; and requesting correction action plans from our contracted health networks when performance is below the required standards.

Member Tolbert requested discussion at a future MAC meeting regarding intellectual disabilities in autism.

Grievance and Appeals Process

Ana Aranda, Interim Director, Grievance and Appeals, provided an overview on the Grievance and Appeals process. A member can submit a grievance anytime and submit an Appeal up to 60 days from the Notice of Action. An acknowledgement letter is mailed to the member or authorized representative within five calendar days indicating that CalOptima is in receipt of their grievance or appeal. The Grievance Resolution Specialist will contact the member if clarification or additional information is needed, assists the member with any immediate needs, and works with internal departments, health networks, and providers to resolve the member's concerns. When a member needs timely access to care, CalOptima coordinates services by contacting the provider to arrange an earlier appointment for the member. Alternatively, CalOptima will coordinate changing the provider referral to obtain a timely appointment. Grievance tracking and trending reports are in place to address areas of improvement, and information is shared with internal and external stakeholders for further action.

Back to Agenda

ADJOURNMENT

Chair Molnar announced that the next MAC meeting is Thursday, September 13, 2018 at 2:30 p.m.

Hearing no further business, Chair Molnar adjourned the meeting at 4:14 p.m.

/s/ Eva Garcia
Eva Garcia
Program Assistant

Approved: September 13, 2018

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

3. Consider Approval of the Updated Strategy for the Disbursement of Years 2-5 OneCare Connect Quality Withhold Payment to CalOptima Community Network (CCN)

Contact

Betsy Ha, Executive Director, Quality and Analytics, (714) 246-8400

Recommended Action

Approve the updated strategy for the disbursement of One Care Connect (OCC) demonstration years (DY) 2-5 (calendar years 2016 – 19), quality withhold payment to CalOptima's Community Network (CCN).

Background

OneCare Connect (OCC) is a Cal MediConnect Plan (Medicare-Medicaid Plan) launched in 2015 for people who qualify for both Medicare and Medi-Cal. OCC is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for both Medicare and Medi-Cal.

These members often have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

At no extra cost to members, OCC adds benefits such as vision care, gym benefits and enhanced dental benefits. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need, when they need them.

To better align quality with cost of care, the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) have constructed a quality withhold process, which applies to Medi-Cal and Medicare Part A/B capitation. Medi-Cal monies are not withheld from health networks. The amounts of the withhold are 1% for Year One (calendar year 2015), 2% for Year Two (calendar year 2016), and 3% for Years Three, Four, and Five (calendar years 2017-2019). All or a part of the withhold may be earned back based on a percentage of quality withhold measures that achieved benchmarks established by DHCS and CMS. Measures and benchmarks are based on final guidance received by CalOptima Regulatory Affairs from CMS and DHCS.

On August 6, 2015, the CalOptima Board of Directors approved the methodology and disbursement of the DY 1 (Measurement Year [MY] 2015) quality withhold that was received from DHCS and CMS in October 2017 and distributed to the health networks. On June 7, 2018, the CalOptima Board

Back to Agenda

of Directors approved the methodology and disbursement of earned quality withhold dollars for DY2-5 to health networks.

Discussion

CalOptima began to participate in the Cal MediConnect program on July 1, 2015. Because CalOptima's participation in Cal MediConnect began midyear, the measurement period for DY 1 was considered July 1, 2015 to December 31, 2015. Subsequent years (years 2-5) began in 2016 and reflect services rendered from January 1 to December 31 of each year.

The quality withhold reduces capitation for both Medi-Cal and Medicare payments to CalOptima by two percent (2%) in Year Two and by three percent (3%) in Years Three, Four, and Five. These withheld funds can be earned back by CalOptima by "passing" a percentage of defined quality withhold measures. Measures are "passed" by managed care plans by achieving the established benchmark set by CMS for each quality withhold measure. The measures are prescribed by DHCS and CMS based on industry standard quality metrics such as HEDIS/Star measures and are communicated to plans via the Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes. Managed care plans earn their withhold back according to the following guidance:

Percent of Measures Passed	Percent of Withhold MMP Receives
0-19%	0%
20-39%	25%
40-59%	50%
60-79%	75%
80-100%	100%

The health networks do not have full accountability for every measure. There are measures that CalOptima has direct responsibility for, and others that have shared responsibility between the delegated health networks and CalOptima.

On June 7, 2018, the CalOptima Board of Directors approved the methodology and disbursement of earned quality withhold dollars for DY2-5 to health networks. Unlike participating health networks, CCN providers are paid at Fee-for-service rates without any quality withholds. In addition, CCN providers are part of the Pay for Value program, wherein they receive incentives for performing on selected clinical and member satisfaction measures. After further review of the program, staff is proposing that there is no need for a distribution strategy for CCN providers as there was no money withheld from the CCN providers.

Back to Agenda

Fiscal Impact

The recommended action to approve the updated strategy for the disbursement of OCC DY 2-5 (calendar years 2016-19), Quality Withhold payment to CCN providers will have no additional fiscal impact to CalOptima. There will be no additional disbursement of funds to CCN providers.

Rationale for Recommendation

These recommendations reflect alignment between CalOptima Community Network providers and CalOptima activities to provide quality healthcare to dual eligible members based on DHCS and CMS directed measures. Greater success in demonstrating quality healthcare will also result in earning back a greater amount of the withhold amount. However, since no funds were ever withheld from CCN providers, there is no basis for distributing withhold funds earned back to those providers.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

Attachments

1. Board Action dated August 6, 2015, Approve the Methodology for and the Disbursement of the Year One, OneCare Connect Quality Withhold Payment to Participating Health Networks
2. Board Action dated June 7, 2018, Approve the Methodology for and the Disbursement of the Year One, OneCare Connect Quality Withhold Payment to Participating Health Networks

/s/ Michael Schrader — *9/26/2018*

Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. F. Approve the Methodology for and the Disbursement of the Year One, OneCare Connect Quality Withhold Payment to Participating Health Networks

Contact
Richard Bock, MD, Deputy Chief Medical Officer, (714) 246-8400

Recommended Action
Approve the methodology for and the disbursement of the Year One, OneCare Connect Quality Withhold payment to participating Health Networks.

Background
July 2012 marked the passage of the Coordinated Care Initiative in California. The Coordinated Care Initiative (CCI) aims to integrate the delivery of medical, behavioral, and long term care services while providing a road map to integrate Medicare and Medi-Cal for people in both programs, called "dual eligible" members.

Central to the CCI model is care coordination. And a critical piece to the model is the care coordination provided for by the member's primary care provider (PCP) and health network. The CCI is expected to produce greater value by improving health outcomes and containing costs; primarily by shifting clinically appropriate service delivery into the home and community and away from expensive institutional settings.

In order to better align quality with cost of care, the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) have constructed a quality withhold process, which applies to Medi-Cal and Medicare Part A/B capitation. The amounts of the withhold are 1% for Year One, 2% for Year Two, and 3% for Year Three. All or a part of the withhold may be earned back based on a methodology developed by DHCS and CMS.

Discussion
CalOptima began to participate in the CCI program on July 1, 2015. Given the delayed start date of the program, the first year of the withhold process will be shortened to reflect services rendered from July 1, 2015 to December 30, 2015.

There are ten quality withhold measures in CCI for Year one. Five of these measures are California-specific and were just released by CMS on July 8, 2015.

- Encounter data
- Getting appointments and care quickly
- Customer service
- Behavioral Health provider participates in care plan development (shared accountability measure, payout shared with county)

Back to Agenda

- Documentation of care goals
- Case Management contact with member
- OneCare Connect Member Advisory Council implementation
- Memorandum of understanding with County Mental Health
- Timely completion of Health Risk Assessments
- Physical access work plan

Capitation for both Medi-Cal and Medicare payments to CalOptima will be reduced by one percent (1%) in Year One. These withheld funds can be earned back by CalOptima in the following manner:

- Plan will pass or fail each measure based on benchmarks
- All withhold measures will be weighted equally
- If a measure cannot be calculated due to timing constraints (of the shortened Year one) or enrollment requirements, it will be removed from the total number of withhold measures on which the plan will be evaluated.
- Payout will be based on:

Percent of Measures Passed	Percent of Withhold MMP Receives
0-19%	0%
20-39%	25%
40-59%	50%
60-79%	75%
80-100%	100%

Distribution of Earned Withhold Funds to the Health Networks:
CalOptima's contracts with the networks provides that "CalOptima will allocate to Physician Group, and amout of revenue withhold attributed to Physician Group's performance on the withhold measures. Final distribution methodology to Physician Group is subject to CalOptima Board of Directors approval." While the health networks do not have full accountability for every measure, there are measures that CalOptima has direct responsibility for and others that have shared responsibility between the delegated health networks and CalOptima. In addition, since the two Behavioral Health measures are governed by language in the three-way contract regarding shared responsibility with County Mental Health, disbursement for them will be described in a future staff recommendation to the Board after further guidance from the State is released. Similarly, distribution of earned back withhold funds attributable to Community Network membership will be described in a future staff recommendation. As 1% of capitation is withheld from CalOptima, the downstream percent of premium (POP) Medicare capitation payments to Health Networks will be similarly reduced. Taking into consideration the truncated duration of Year One and continuing regulatory refinement of the program, the methodology that staff is proposing for Year One provides that Medicare withhold funds which are earned back by CalOptima will be shared with the Health Networks using the identical POP formula.

Back to Agenda

- For example, if CalOptima's revenue is $1,000 per member per month (PMPM), the quality withhold is 1%, and a networks's POP is 35%, the network's capitation will be 35% x $990, which is $346.50 PMPM.

- Assuming CalOptima recoups the full withhold of $10, the network will receive 35%, or $3.50 PMPM.

- Future distribution formulae for Years 2 and 3 may take into account the Health Networks' per cent responsibility for, and the relative performance on, the expanded measure set, but this simpler approach is more appropriate for Year One.

- If CalOptima does not recoup any withhold money, then no Quality Withhold money will be paid out to any network regardless of their performance on the quality measures.

Eligibility to receive any withhold monies earned by CalOptima will be dependent on the health network's good standing with CalOptima and their active contractual status with CalOptima during any part of the measurement period as well as at the time of distribution.

Fiscal Impact
The recommended action is projected to be budget neutral to CalOptima. Distributions to health networks will not exceed the amount of withheld funds that are earned back.

Rationale for Recommendation
These recommendations reflect alignment between health network and CalOptima activities to provide quality healthcare to dual eligible members based on DHCS and CMS directed measures. Greater success in demonstrating quality healthcare will also result in earning back a greater amount of the withhold amount.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/31/2015*
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

Consent Calendar

3. Consider Approval of the Methodology for and the Disbursement of Years 2-5 OneCare Connect Quality Withhold Payment to Participating Health Networks

Contact

Richard Bock, M.D., Deputy Chief Medical Officer, (714) 246-8400

Recommended Action

Approve the methodology for and the disbursement strategy of One Care Connect (OCC) demonstration years (DY) 2-5 (calendar years 2016 – 19), Quality Withhold payment to contracted Health Networks, including CalOptima's Community Network (CCN).

Background

OneCare Connect (OCC) is a Cal MediConnect Plan (Medicare-Medicaid Plan) launched in 2015 for people who qualify for both Medicare and Medi-Cal. OCC is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for both Medicare and Medi-Cal.

These members often have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

At no extra cost to members, OCC adds benefits such as vision care, gym benefits and enhanced dental benefits. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need, when they need them.

To better align quality with cost of care, the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) have constructed a quality withhold process, which applies to Medi-Cal and Medicare Part A/B capitation. Medi-Cal monies are not withheld from health networks. The amounts of the withhold are 1% for Year One (calendar year 2015), 2% for Year Two (calendar year 2016), and 3% for Years Three, Four, and Five (calendar years 2017-2019). All or a part of the withhold may be earned back based on a percentage of quality withhold measures that achieved benchmarks established by DHCS and CMS. Measures and benchmarks are based on final guidance received by CalOptima Regulatory Affairs from CMS and DHCS.

On August 6, 2015, the CalOptima Board of Directors approved the methodology and disbursement of the DY 1 (MY2015) quality withhold that was received from DHCS and CMS in October 2017 and

Back to Agenda

distributed to the health networks. Additional Board action is required for the methodology and distribution of earned quality withhold dollars for DY2-5.

Discussion

CalOptima began to participate in the Cal MediConnect program on July 1, 2015. Because CalOptima's participation in Cal MediConnect began midyear, the measurement period for DY 1 was considered July 1, 2015 to December 31, 2015. Subsequent years (years 2-5) began in 2016 and reflect services rendered from January 1 to December 31 of each year.

The quality withhold reduces capitation for both Medi-Cal and Medicare payments to CalOptima by two percent (2%) in Year Two and by three percent (3%) in Years Three, Four, and Five. These withheld funds can be earned back by CalOptima by "passing" a percentage of defined quality withhold measures. Measures are "passed" by managed care plans by achieving the established benchmark set by CMS for each quality withhold measure. The measures are prescribed by DHCS and CMS based on industry standard quality metrics such as HEDIS/Star measures and are communicated to plans via the Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes. Managed care plans earn their withhold back according to the following guidance:

Percent of Measures Passed	Percent of Withhold MMP Receives
0-19%	0%
20-39%	25%
40-59%	50%
60-79%	75%
80-100%	100%

While the health networks do not have full accountability for every measure, there are measures that CalOptima has direct responsibility for and others that have shared responsibility between the delegated health networks and CalOptima.

CalOptima proposes the following methodology to distribute earned funds back to contracted health networks:

Back to Agenda

Health Network Scoring

- Quality Points is the sum of all points earned for each measure.

Health Network Measure Performance Points

- Uses NCQA National Medicaid HEDIS Percentiles as benchmark for NCQA HEDIS measures
- Uses CMS Star Cut Points as Benchmark for CMS Star Measure(s)
- Minimum denominator of 1% of Total Denominator

Quality Points	Star / Percentile
1	3 Stars / 50th Percentile
2	4 Stars / 75th Percentile
3	5 Stars / 90th Percentile

Health Plan Measure Points

- Benchmark is set by Cal MediConnect.
- Points based on CalOptima's rate for measure
  - 1 point if CalOptima passes measure
  - 0 point if CalOptima does not pass measure

Distribution of Earned Withhold Funds to the Health Networks

CalOptima's contracts with the health networks provides that "CalOptima will allocate to Physician Group an amount of revenue withhold attributed to Physician Group's performance on the withhold measures. Final distribution methodology to Physician Group is subject to CalOptima Board of Directors approval."

- The methodology that staff is proposing for DY2-5 provides that Medicare withhold funds which are earned back by CalOptima will be distributed to the Health Networks, including the CalOptima Community Network (CCN), based on performance and percent of premium (POP). The distribution to a health network will not exceed the amount of funds originally withheld from its capitation. If CMS does not return withheld funds based on performance results, then no Quality Withhold money will be paid out to any network, regardless of their performance on the quality measures.
- Eligibility to receive any withhold monies earned by CalOptima will be dependent on the health network's good standing with CalOptima and their active contractual status with CalOptima during any part of the measurement period, as well as at the time of distribution.

Back to Agenda

- Distribution of earned back withhold funds attributable to CalOptima Community Network (CCN) membership will be similar to other health network distribution of withheld dollars. Staff will return at a later date to propose a distribution strategy specifically to CCN providers.
- Withhold money will be distributed to health networks, including CalOptima Community Network (CCN), after CalOptima receives the withhold money from CMS.
- Health Networks will receive their withhold money within 90 days of CalOptima receiving the withhold money from CMS.
- CalOptima contracts with health networks under various arrangements and the allocation for each health network will depend on the withheld amounts received from CMS and the health network performance on the quality measures benchmarked by CMS.
- Health Network payment will depend on the arrangement with CalOptima. Based on current capitation contract arrangement with health networks for CMS revenue, Health Maintenance Organizations (HMOs) will receive their contractually agreed percentage of the withheld amounts for professional services and for hospital services.
- For Physician Hospital Consortiums (PHCs) however, the Physician side of the PHCs will receive their contractually agreed percentage of the withheld amounts for professional services but CalOptima will pay the contractually agreed percentage for hospital services directly to the hospitals.
- Shared Risk Groups (SRGs) will also receive their contractually agreed percentage of the withheld amounts for professional services but the hospital allocation will be contributed to the SRG pool.

Fiscal Impact

The recommended action is budget neutral to CalOptima. The amount of Medicare quality withhold funds earned back by CalOptima, if any, will be sufficient to fund distributions to health networks and CCN with no additional fiscal impact to the operating budget.

Rationale for Recommendation

These recommendations reflect alignment between health network and CalOptima activities to provide quality healthcare to dual eligible members based on DHCS and CMS directed measures. Greater success in demonstrating quality healthcare will also result in earning back a greater amount of the withhold amount.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

Back to Agenda

Attachment
Board Action dated August 6, 2015, Approve the Methodology for and the Disbursement of the Year One, OneCare Connect Quality Withhold Payment to Participating Health Networks

/s/ Michael Schrader *5/30/2018*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

4. Consider Modification of Claims Payment Policies Associated with the Implementation of the Whole-Child Model

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400

Recommended Action

Recommend authorizing a transition period of six months for payment of certain claims for children enrolled in California Children's Services (CCS) prior to January 1, 2019 that would be denied under CalOptima Direct, CalOptima Community Network, or a Health Network to allow for adequate transition of Service Authorizations Requests (SARs) from the California Children's Services Program to CalOptima under the Whole-Child Model.

Background

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

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

Discussion

CalOptima recognizes that the authorization processes for claims payment differs between the CCS program and managed care. CalOptima and its health networks issue authorizations based on member, provider, and service code levels. Claims payments, when applicable, are based on the details in the authorization. Whereas, the CCS program issues SARs based on member and diagnosis/conditions. Multiple claims potentially involving multiple providers and multiple services/visits can be paid based on a single SAR. While CalOptima plans to proactively outreach to members and providers to obtain detailed information needed to issue new authorizations, some claims for CCS services may be inadvertently submitted without a CalOptima or health network authorization.

Back to Agenda

The overall expectation is that CalOptima or the health networks will issue new authorizations for CCS services. Processes have been established with the local CCS program to forward misdirected authorization requests to CalOptima. However, in order to promote a smooth transition to WCM and ensure continued access for members, CalOptima staff recommends implementing a transition period that permits claims payments in certain situations when there is no CalOptima or health network authorization. The recommendation is that for dates of service from January 1, 2019 through June 30, 2019, CalOptima and health networks pay for CCS services provided by contracted or non-contracted providers, for eligible children who were enrolled in CCS program prior to January 1, 2019 as long as there is an active CCS SAR and other claim payment requirements are met. All inpatient services are excluded from this proposed exception and, depending on member eligibility, will require a CalOptima or health network authorization.

Remittance Advice (RA) issued by CalOptima will indicate that any future services will need a CalOptima or Health Network authorization; the expectation is that the Health Networks will follow a similar process to notify providers. In addition, CalOptima Provider and Health Network Relations staff will coordinate with the health networks to outreach to providers regarding the transition from SARs to CalOptima/Health Network authorizations.

Fiscal Impact
The fiscal impact of the recommended action to authorize a transition period from January 1, 2019, through June 30, 2019, to pay certain claims under the WCM program is currently unknown. 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. However, Management has included projected revenues and expenses associated with the WCM program in the Board-approved CalOptima Fiscal Year 2018-19 Operating Budget to fund all current year operating costs. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue is sufficient to support the WCM program.

Rationale for Recommendation
Staff recommends providing a six-month transition period to promote a smooth transition to WCM, minimize disruption of member care, and maintain positive relations with CCS providers.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
5. Consider Accepting and Receiving and Filing the Fiscal Year 2018 CalOptima Audited Financial Statements

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

Recommended Action
Recommend accepting and receiving and filing the Fiscal Year (FY) 2018 CalOptima consolidated audited financial statements as submitted by independent auditors Moss-Adams, LLP.

Background
CalOptima has contracted with financial auditors Moss-Adams, LLP since May 21, 2015, to complete CalOptima's annual financial audit. At the May 17, 2018, meeting of the CalOptima Finance and Audit Committee, Moss-Adams presented the 2018 Audit Plan. The plan includes performing mandatory annual consolidated financial statement audit and drafting of the consolidated financial statements for the year ending June 30, 2018.

Discussion
Moss-Adams conducted the interim audit from May 21, 2018, through May 25, 2018, and the on-site year-end audit from July 23, 2018, through August 17, 2018. The significant audit areas that Moss-Adams reviewed included:

- Capitation revenue and receivables;
- Cash and cash equivalents;
- Investments; and
- Medical claims liability, capitation payable and obligations payable to State of California.

Results from CalOptima's FY 2018 Audit were positive. The auditor made no changes in CalOptima's approach to applying critical accounting policies and did not report having encountered any significant difficulties during the audit. Additionally, there were no material misstatements identified by the auditor. As such, Management recommends that the Board accept the CalOptima FY 2018 audited financial statements as presented.

Fiscal Impact
There is no fiscal impact related to this recommended action.

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

Back to Agenda

Attachments

1. FY 2018 CalOptima Audited Financial Statements
2. Presentation by Moss-Adams, LLP

/s/ Michael Schrader — *9/26/2018*

Authorized Signature — **Date**

Back to Agenda

REPORT OF INDEPENDENT AUDITORS AND
CONSOLIDATED FINANCIAL STATEMENTS
WITH SUPPLEMENTARY INFORMATION

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY/DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE/DBA CALOPTIMA

June 30, 2018 and 2017

MOSSADAMS

Back to Agenda

Table of Contents

Back to Agenda

The intent of management's discussion and analysis of CalOptima's consolidated financial performance is to provide readers with an overview of the agency's financial activities for the fiscal years ended June 30, 2018 and 2017. Readers should review this summation in conjunction with CalOptima's consolidated financial statements and accompanying notes to the consolidated financial statements to enhance their understanding of CalOptima's financial performance.

Key Operating Indicators

The table below compares key operating indicators for CalOptima for the fiscal years ended June 30, 2018, 2017 and 2016:

Key Operating Indicators	2018	2017 (as restated)	2016
Members (at end of fiscal period):			
Medi-Cal program	763,824	772,228	776,713
OneCare	1,418	1,121	1,174
OneCare Connect	14,768	15,505	29,416
PACE	267	212	168
Average member months			
Medi-Cal program	772,511	777,057	765,938
OneCare	1,372	1,237	6,879
OneCare Connect	15,079	16,834	9,626
PACE	239	190	135
Operating revenues (in millions)	$ 3,446	$ 3,549	$ 3,148
Operating expenses (in millions)			
Medical expenses	3,292	3,400	3,022
Administrative expenses	132	111	107
Operating income (in millions)	$ 22	$ 38	$ 19
Operating revenues PMPM (per member per month)	$ 364	$ 372	$ 337
Operating expenses PMPM			
Medical expenses PMPM	348	356	323
Administative expenses PMPM	14	12	11
Opeating income (loss) PMPM	$ 2	$ 4	$ 3
Medical loss ratio	96%	96%	96%
Administrative expenses ratio	4%	3%	3%
Premium tax revenue and expenses not included above			
Operating revenues (in millions)	143	138	114
Administrative expenses (in millions)	143	138	114

Overview of the Consolidated Financial Statements

This annual report consists of consolidated financial statements and notes to those statements, which reflect CalOptima's financial position as of June 30, 2018 and 2017, and results of its operations for the fiscal years ended June 30, 2018 and 2017. The consolidated financial statements of CalOptima, including the consolidated statements of net position, statements of revenues, expenses and changes in net position, and statements of cash flows, represent the consolidated accounts and transactions of the five (5) programs – Medi-Cal, OneCare, OneCare Connect, Program of All-inclusive Care for the Elderly (PACE), and CalOptima Foundation.

- The consolidated statements of net position include all of CalOptima's assets, deferred outflows of resources, liabilities, and deferred inflows of resources, using the accrual basis of accounting, as well as an indication about which assets and deferred outflows of resources are utilized to fund obligations to providers and which are restricted as a matter of Board of Directors' policy.

- The consolidated statements of revenues, expenses and changes in net position present the results of operating activities during the fiscal year and the resulting increase or decrease in net position.

- The consolidated statements of cash flows report the net cash provided by or used in operating activities, as well as other sources and uses of cash from investing and capital and related financing activities.

The following discussion and analysis addresses CalOptima's overall program activities. CalOptima's Medi-Cal program accounted for 89.8 percent, 88.6 percent, and 89.4 percent of its annual revenues during fiscal years 2018, 2017, and 2016, respectively. CalOptima's OneCare accounted for 0.5 percent, 0.5 percent, and 3.3 percent of its annual revenues during fiscal years 2018, 2017, and 2016, respectively. CalOptima's OneCare Connect program accounted for 9.1 percent, 10.5 percent and 7.0 percent of its annual revenues during fiscal year 2018, 2017 and 2016, respectively. All other programs consolidated accounted for 0.6 percent, 0.4 percent, and 0.3 percent of CalOptima's annual revenues during fiscal years 2018, 2017, and 2016, respectively.

CalOptima Foundation (the Foundation) was formed as a not-for-profit benefit corporation in 2010 and is dedicated to the betterment of public health care services in Orange County. CalOptima has sole control over the activities of the Foundation and as such, the activities of the Foundation are included in the consolidated financial statements of CalOptima.

2018 and 2017 Financial Highlights

As of June 30, 2018 and 2017, total assets and deferred outflows of resources were approximately $1,879.1 million and $2,743.0 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately $764.5 million and $718.6 million, respectively.

Net position increased by approximately $45.8 million, or 6.4 percent, during fiscal year 2018 and increased by approximately $56.2 million, or 8.5 percent, during fiscal year 2017.

Table 1a: Condensed Consolidated Statements of Net Position as of June 30,
(Dollars in Thousands)

Financial Position	2018	2017 (as restated)	Change From 2017 Amount	Change From 2017 Percentage
ASSETS				
Current assets	$ 1,278,680	$ 2,141,667	$ (862,987)	-40.3%
Board-designated assets and restricted cash	538,548	535,438	3,110	0.6%
Capital assets, net	50,758	54,301	(3,543)	-6.5%
Total assets	$ 1,867,986	$ 2,731,406	$ (863,420)	-31.6%
DEFERRED OUTFLOWS OF RESOURCES	$ 11,133	$ 11,577	$ (444)	-3.8%
Total assets and deferred outflows of resources	$ 1,879,119	$ 2,742,983	$ (863,864)	-31.5%
LIABILITIES				
Current liabilities	$ 1,061,545	$ 1,981,195	$ (919,650)	-46.4%
Other liabilities	49,766	41,809	7,957	19.0%
Total liabilities	$ 1,111,311	$ 2,023,004	$ (911,693)	-45.1%
DEFERRED INFLOWS OF RESOURCES	$ 3,329	$ 1,340	$ 1,989	148.4%
NET POSITION				
Net investment in capital assets	$ 50,637	$ 54,104	$ (3,467)	-6.4%
Restricted	89,037	98,445	(9,408)	-9.6%
Unrestricted	624,805	566,090	58,715	10.4%
Total net position	$ 764,479	$ 718,639	$ 45,840	6.4%
Total liabilities, deferred inflows of resources and net position	$ 1,879,119	$ 2,742,983	$ (863,864)	-31.5%

Current assets decreased $863.0 million from $2,141.7 million in 2017 to $1,278.7 million in 2018, primarily in cash, short-term investments and premium receivables categories. Current liabilities decreased $919.7 million from $1,981.3 million in 2017 to $1,061.5 million in 2018. The decrease is mainly related to recoupment from California Department of Health Care Services (DHCS) on Medi-Cal expansion rate changes and shared risk pool payouts to the health networks.

2018 and 2017 Financial Highlights (continued)

Board-designated assets and restricted cash increased by $3.1 million and $59.3 million in fiscal years 2018 and 2017, respectively. The Board of Directors' policy is to augment Board-designated assets to provide a desired level of funds between 1.4 months and 2 months of premium revenue to meet future contingencies. CalOptima's reserve level of tier one and two investment portfolios as of June 30, 2018 is at 1.9 times of monthly average premium revenue. CalOptima is also required to maintain a $300,000 restricted deposit as a part of the Knox-Keene Health Care Service Plan Act of 1975.

2017 and 2016 Financial Highlights

As of June 30, 2017 and 2016, total assets and deferred outflows of resources were approximately $2,743.0 million and $2,307.8 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately $718.6 million and $662.5 million, respectively.

Net position increased by approximately $56.2 million, or 8.5 percent, during fiscal year 2017 and increased by approximately $32.5 million, or 5.2 percent during fiscal year 2016.

Table 1a: Condensed Consolidated Statements of Net Position as of June 30,
(Dollars in Thousands)

Financial Position	2017 (as restated)	2016	Change From 2016 Amount	Change From 2016 Percentage
ASSETS				
Current assets	$ 2,141,667	$ 1,771,671	$ 369,996	20.9%
Board-designated assets and restricted cash	535,438	476,146	59,292	12.5%
Capital assets, net	54,301	54,996	(695)	-1.3%
Total assets	$ 2,731,406	$ 2,302,813	$ 428,593	18.6%
DEFERRED OUTFLOWS OF RESOURCES - PENSION CONTRIBUTIONS	$ 11,577	$ 5,003	$ 6,574	131.4%
Total assets and deferred outflows of resources	$ 2,742,983	$ 2,307,816	$ 435,167	18.9%
LIABILITIES				
Current liabilities	$ 1,981,195	$ 1,609,330	$ 371,865	23.1%
Other liabilities	41,809	33,864	7,945	23.5%
Total liabilities	$ 2,023,004	$ 1,643,194	$ 379,810	23.1%
DEFERRED INFLOWS OF RESOURCES - EXCESS EARNINGS	$ 1,340	$ 2,155	$ (815)	-
NET POSITION				
Net investment in capital assets	$ 54,104	$ 54,995	$ (891)	-1.6%
Restricted	98,445	89,284	9,161	10.3%
Unrestricted	566,090	518,188	47,902	9.2%
Total net position	$ 718,639	$ 662,467	$ 56,172	8.5%
Total liabilities, deferred inflows of resources and net position	$ 2,742,983	$ 2,307,816	$ 435,167	18.9%

2017 and 2016 Financial Highlights (continued)

Current assets increased $370.0 million from $1,771.7 million in 2016 to $2,141.7 million in 2017. The increase in current assets is due to increases in cash, short-term investments and premium receivables. Current liabilities increased $ 372.0 million from $1,609.3 million in 2016 to $1,981.2 million in 2017. The increase is mainly due to additional payables to the health networks of approximately $173.0 million related to shared risk payout estimates and an increase of $549.4 million in the Due to DHCS liability account, which is the result from the change in categorization of excess payments related to Medi-Cal expansion rate changes from unearned revenue. Both are offset by a decrease of $387.9 million in the unearned revenue for the above-mentioned category change. The net increase of the excess Medi-Cal expansion payments is $161.5 million from fiscal year 2016.

2018 and 2017 Results of Operations

CalOptima's fiscal year 2018 operations and nonoperating revenues resulted in a $45.8 million increase in net position, $10.4 million less compared to a $56.2 million increase in fiscal year 2017. The following table reflects the changes in revenues and expenses for 2018 compared to 2017:

Table 2a: Consolidated Revenues, Expenses and Changes in Net Position for
Fiscal Years Ended June 30,
(Dollars in Thousands)

Results of Operations	2018	2017 (as restated)	Change From 2017 Amount	Change From 2017 Percentage
CAPITATION REVENUES	$ 3,445,699	$ 3,549,462	$ (103,763)	-2.9%
OTHER INCOME	-	27	(27)	-100.0%
Total operating revenues	3,445,699	3,549,489	(103,790)	-2.9%
MEDICAL EXPENSES	3,291,712	3,399,612	(107,900)	-3.2%
ADMINISTRATIVE EXPENSES	131,847	111,428	20,419	18.3%
Total operating expenses	3,423,559	3,511,040	(87,481)	-2.5%
Operating income	22,140	38,449	(16,309)	-42.4%
NONOPERATING REVENUES AND EXPENSES	23,700	17,724	5,976	33.7%
Increase in net position	45,840	56,173	(10,333)	-18.4%
NET POSITION, beginning of year	718,640	662,467	56,173	8.5%
NET POSITION, end of year	$ 764,480	$ 718,640	$ 45,840	6.4%

2018 and 2017 Operating Revenues

The decrease in consolidated operating revenues of $103.8 million in fiscal year 2018 is attributable to lower enrollment in fiscal year 2018 comparing to fiscal year 2017, overall rate decreases in the Medi-Cal line of business for both Medi-Cal classic and Medi-Cal expansion members, and the discontinuation of In-Home Supportive Services (IHSS) beginning January 2018. Part of the revenue decrease is offset by the recognition of prior year deferred revenue from the Coordinated Care Initiative (CCI) program after reconciling the blended rates with DHCS.

2018 and 2017 Medical Expenses

Overall medical expenses decreased by $107.9 million or 3.2 percent in fiscal year 2018, totaling $3,292.7 million, compared to $3,399.6 million in fiscal year 2017. CalOptima's medical loss ratio, or medical expenses as a percentage of operating revenues, was 95.5 percent in fiscal year 2018 similar to the result in fiscal year 2017 which was 95.8 percent.

Medi-Cal provider capitation, comprised of capitation payments to CalOptima's contracted health networks, increased by 8.4 percent from fiscal year 2017 to fiscal year 2018 due to the transition of a shared risk group network to a HMO model during the year. Capitated member enrollment accounted for approximately 76.4 percent of CalOptima's enrollment, averaging 590,204 members during fiscal year 2018, and 78.6 percent of CalOptima's enrollment, averaging 610,893 members during fiscal year 2017. Included in the capitated environment are 198,508 or 33.6 percent and 298,552 or 48.9 percent members in a shared risk network for fiscal years 2018 and 2017, respectively. Shared Risk Networks receive capitation for professional services and are claims-based for hospital services.

Medi-Cal capitation expenses totaled $1,068.4 million in fiscal year 2018, compared to $985.2 million in fiscal year 2017. The increase reflects the transition of one group to HMO, and additional capitation expenses relating to Proposition 56 (the Research and Prevention Tobacco Tax Act of 2016), which authorizes supplemental payments to impacted physician services.

Medi-Cal claim expense to providers and facilities, including Long-term care (LTC) services decreased by 10.2 percent from fiscal year 2017 to fiscal year 2018. This decrease is attributable to lower enrollment, the transition of one shared risk network to HMO as mentioned above, and the discontinuation of In-Home Supportive Services (IHSS) services beginning January 2018. The decrease is offset by additional IHSS expenses recorded based on an updated IHSS report from DHCS for service dates between fiscal year 2016 to fiscal year 2018.

Pharmacy costs increased by 4.8 percent in fiscal year 2018, compared to fiscal year 2017. Results from fiscal year 2018 reflects an increase pharmacy drug prices.

In addition to items mentioned above, total Quality Assurance Fee (QAF) payments received and passed through to hospitals increased from $307.8 million to $402.3 million from fiscal year 2017 to fiscal year 2018. These receipts and payments are not included in the consolidated statements of revenues, expenses and changes in net position.

2018 and 2017 Administrative Expenses

Total administrative expenses were $131.8 million in 2018 compared to $111.4 million in 2017. Overall administrative expenses increased by 18.3 percent or $20.4 million, due to increases in salaries and benefits for behavioral health services brought in house, along with a CalPERS actuarial valuation increase of $10 million related to a discount rate reduction from 7.65% to 7.15%. The administrative expenses for both 2018 and 2017 reflected the implementation of Government Accounting Standards Board (GASB) Statement No. 75 *Accounting and Financial Reporting for Postemployment Benefits Other than Pensions* for CalOptima's other post-employment benefits for decreases of $2.1 million and $2.3 million, respectively. During fiscal years 2018 and 2017, respectively, CalOptima's administrative expenses were 3.8 percent and 3.1 percent of total operating revenues.

2017 and 2016 Results of Operations

CalOptima's fiscal year 2017 operations and nonoperating revenues resulted in a $56.2 million increase in net position, $23.7 million higher compared to a $32.5 million increase in fiscal year 2016. The following table reflects the changes in revenues and expenses for 2017 compared to 2016:

Table 2b: Consolidated Revenues, Expenses, and Changes in Net Position for
Fiscal Years Ended June 30,
(Dollars in Thousands)

Results of Operations	2017 (as restated)	2016	Change From 2016 Amount	Change From 2016 Percentage
CAPITATION REVENUES	$ 3,549,462	$ 3,148,260	$ 401,202	12.7%
OTHER INCOME	27	305	(278)	-91.1%
Total operating revenues	3,549,489	3,148,565	400,924	12.7%
MEDICAL EXPENSES	3,399,612	3,022,418	377,194	12.5%
ADMINISTRATIVE EXPENSES	111,428	107,182	4,246	4.0%
Total opeating expenses	3,511,040	3,129,600	381,440	12.2%
Operating income	38,449	18,965	19,484	102.7%
NONOPERATING REVENUES AND EXPENSES	17,724	13,548	4,176	30.8%
Increase in net position	56,173	32,513	23,660	72.8%
NET POSITION, beginning of year	662,467	629,954	32,513	5.2%
NET POSITION, end of year	$ 718,640	$ 662,467	$ 56,173	8.5%

2017 and 2016 Operating Revenues

The increase in consolidated operating revenues of $401.2 million in fiscal year 2017 is attributable to additional revenue from rate increases, continued growth in Medi-Cal expansion and update in the revenue recognition methodology for Care Coordinated Initiative (CCI) and LTC services. An update to the revenue recognition methodology for CCI resulted in additional revenue of $64.7 million for fiscal year 2016 reflected in fiscal year 2017. Similarly, $56.3 million of additional revenue for LTC services for fiscal year 2016 was reflected in fiscal year 2017.

2017 and 2016 Medical Expenses

Overall medical expenses increased by 12.5 percent in fiscal year 2017, totaling $3,399.6 million, compared to $3,022.4 million in fiscal year 2016. CalOptima's medical loss ratio, or medical expenses as a percentage of operating revenues, was 95.8 percent in fiscal year 2017 compared to 96.0 percent in fiscal year 2016.

Medi-Cal provider capitation, comprising capitation payments to CalOptima's contracted health networks, increased by 5.3 percent from fiscal year 2016 to fiscal year 2017 due to the transition of one shared risk group network and a managed behavior health organization (MBHO) to an HMO model during the year. Capitated member enrollment accounted for approximately 78.6 percent of CalOptima's enrollment, averaging 610,893 members during fiscal year 2017, and 80.0 percent of CalOptima's enrollment, averaging 612,704 members during fiscal year 2016. Included in the capitated environment are 298,552 or 48.9 percent and 342,498 or 44.7 percent members in a shared risk network for fiscal years 2017 and 2016, respectively. Shared risk networks receive capitation for professional services and are claim-based for hospital services.

Medi-Cal capitation expenses totaled $985.2 million in fiscal year 2017, compared to $935.4 million in fiscal year 2016, which reflects the increased enrollment in capitated networks.

Medi-Cal claim expense to providers and facilities, including LTC facilities increased by 16.2 percent from fiscal year 2016 to fiscal year 2017. This increase is attributable to an overall increase in cost per member, enrollment and a change in methodology to account for IHSS benefits.

In addition to the above Medi-Cal revenues and claims expenses in fiscal year 2017, QAF payments received and passed through to hospitals increased from $42.1 million to $307.8 million from fiscal year 2016 to fiscal year 2017. These receipts and payments are not included in the consolidated statements of revenues, expenses and changes in net position.

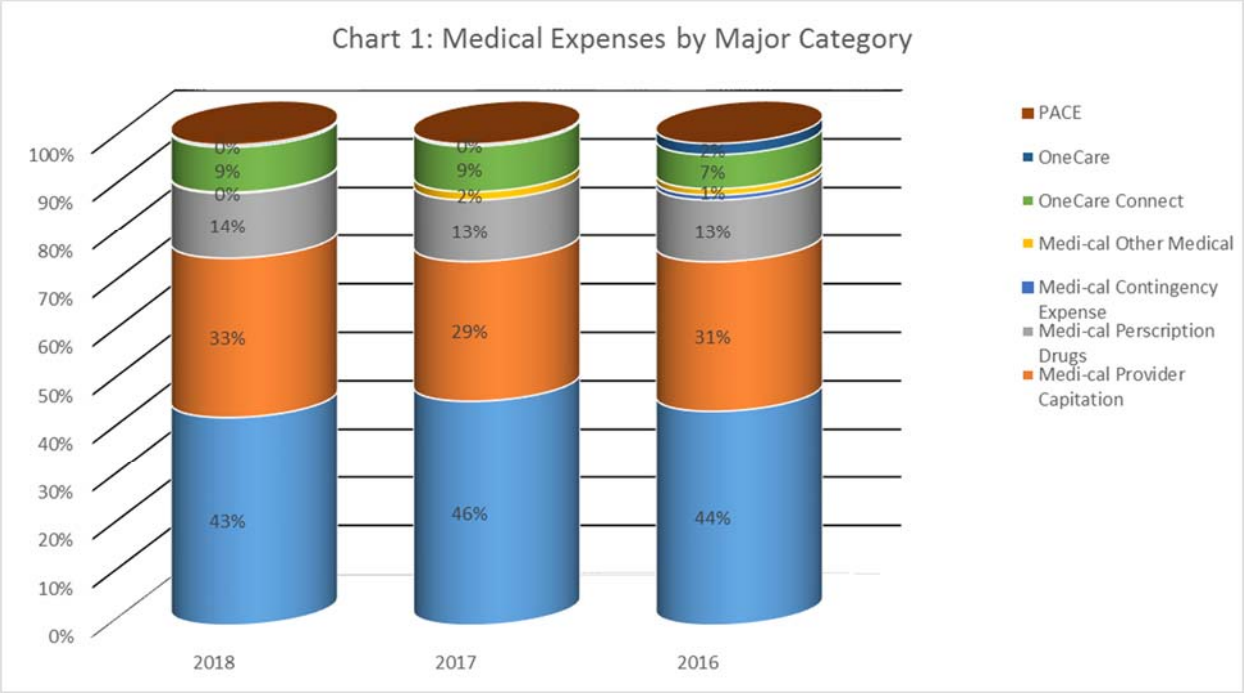
Pharmacy costs increased by 8.6 percent in fiscal year 2017, compared to fiscal year 2016. Results from fiscal year 2017 reflect higher enrollment and increase Pharmacy drug prices.

2017 and 2016 Administrative Expenses

Total administrative expenses were $111.4 million in 2017 compared to $107.2 million in 2016. Overall administrative expenses increased by 4 percent or $4.2 million, due to increases in salaries and benefits. During fiscal years 2017 and 2016, respectively, administrative expenses were 3.1 percent and 3.4 percent of operating revenues.

2018, 2017, and 2016 Medical Expenses by Major Category

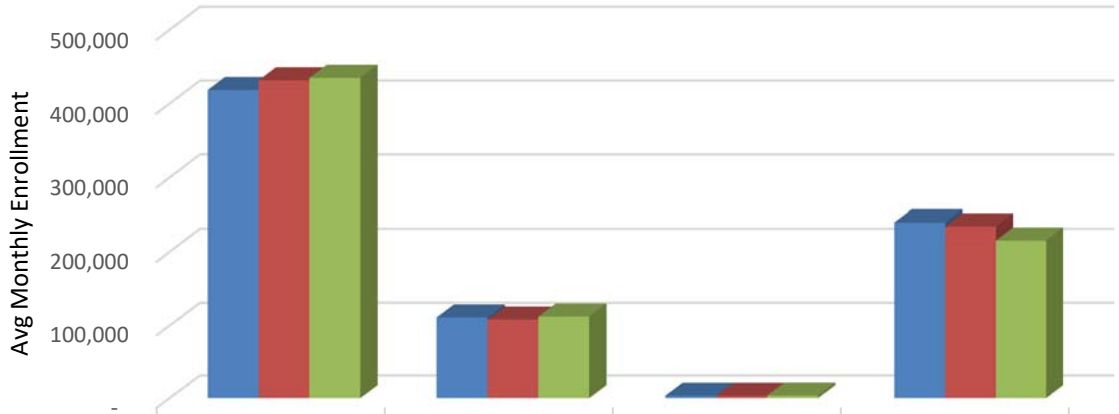
Below is a comparison chart of medical expenses by major category and their respective percentages of the overall medical expenditures by fiscal year.



2018, 2017, and 2016 Enrollment

During fiscal year 2018, CalOptima served an average of 772,511 Medi-Cal members per month compared to an average of 777,057 members per month in 2017, and 765,938 members per month in 2016. The chart below displays a comparative view of average monthly membership by Medi-Cal aid category during 2018, 2017, and 2016:

Chart 2: Medi-Cal Membership by Aid Category
(Shown as Average Member Months)



	TANF	Disabled/Aged	LTC	MCE
2018	418,378	111,158	3,440	239,535
2017	431,452	108,130	3,283	234,192
2016	434,854	112,328	3,518	215,238

Significant aid categories are defined as follows:

Temporary Assistance to Needy Families (TANF) includes families, children, and poverty-level members who qualify for the TANF federal welfare program, which provides cash aid and job-search assistance to poor families. TANF also includes members who migrated from CalOptima, Health Net, and Kaiser Healthy Family programs.

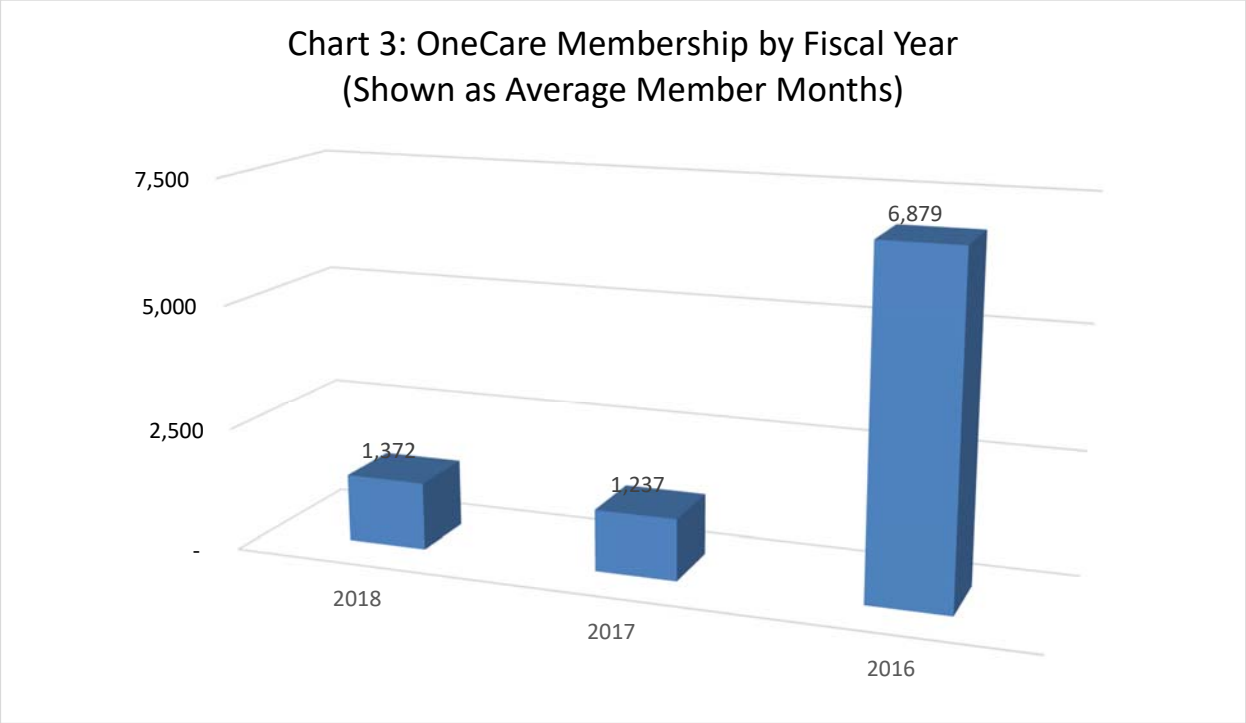
Disabled and Aged includes individuals who have met the criteria for disability set by the Social Security Administration, and individuals of 65 years of age and older who receive supplemental security income (SSI) checks, or are medically needy, or have an income of 100 percent or less of the federal poverty level.

LTC includes frail elderly, nonelderly adults with disabilities, and children with developmental disabilities and other disabling conditions requiring long-term care services.

Medi-Cal Expansion program (MCX and MSI) includes adults without children, ages 19-64, qualified based upon income, as required by the Patient Protection and Affordable Care Act (ACA).

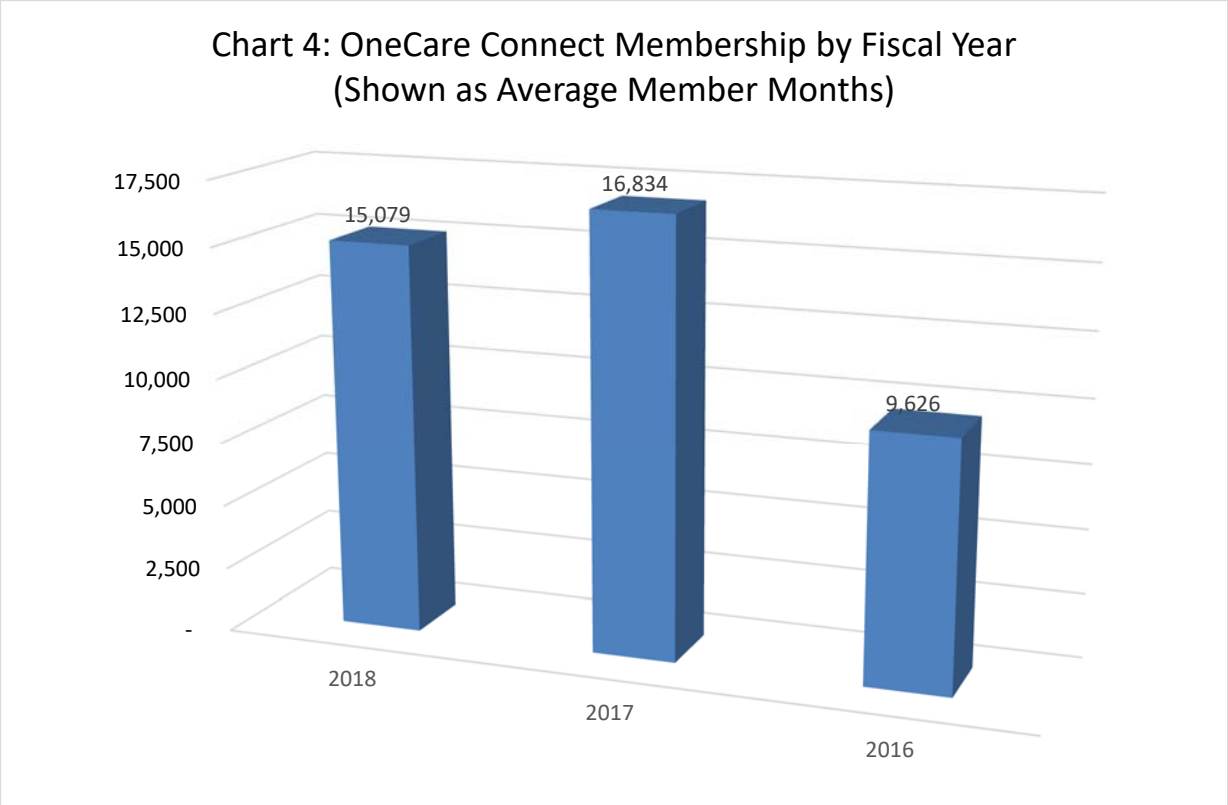
2018, 2017, and 2016 Enrollment (continued)

OneCare was introduced in fiscal year 2006 to service the unique Medicare Advantage Special Needs Plan. It provides a full range of health care services to average member months of 1,372, 1,237, and 6,879 for the years ended June 30, 2018, 2017, and 2016, respectively. Members are eligible for both the Medicare and Medi-Cal programs. The membership decrease in 2017 was primarily due to OneCare members transitioning to CalOptima's OneCare Connect. The chart below displays the average member months for the past three years.



2018, 2017, and 2016 Enrollment (continued)

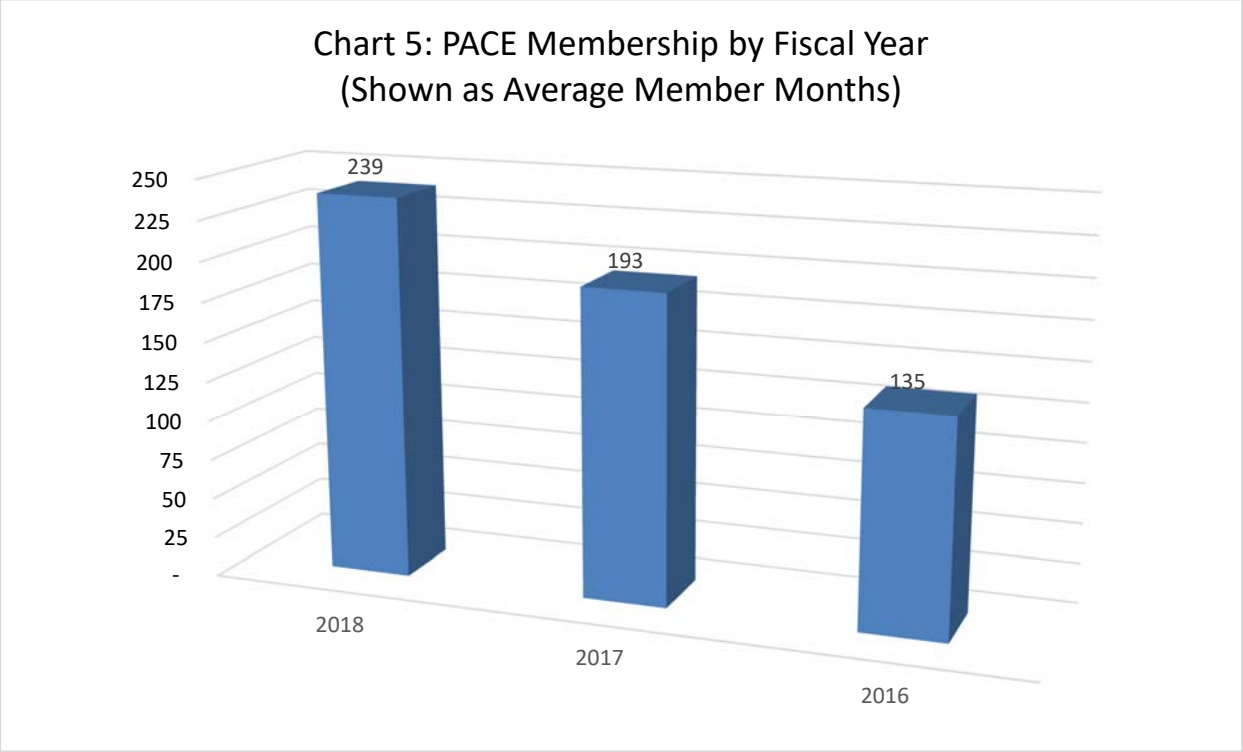
CalOptima launched OneCare Connect (OCC) program to serve dual eligible members in Orange County on July 1, 2015. This new program combines members' Medicare and Medi-Cal coverage and adds other benefits and supports. Average member months were 15,079 in fiscal year 2018. The chart below displays the average member months for the past three years.



Back to Agenda

2018, 2017, and 2016 Enrollment (continued)

PACE (Program of All-Inclusive Care for the Elderly) started operation in October 2013. It is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community. It provides a full range of health care services to average member months of 239, 193, and 135 for the years ended June 30, 2018, 2017, and 2016, respectively. The chart below displays the average member months for the past three years.



Economic Factors and the State's Fiscal Year 2018 Budget

On June 27, 2018, Governor Jerry Brown signed the Fiscal Year (FY) 2018-19 budget. The budget is consistent with his overall focus for a balanced state budget while addressing his key priorities: plan for the next recession by filling the Rainy-Day Fund, move government closer to the people, increase funding for schools, counteract the effects of poverty and support job creation, combat climate change, strengthen infrastructure, and pay down debts and liabilities.

Economic Factors and the State's Fiscal Year 2018 Budget (continued)

General Fund spending in the budget package is $138.7 billion, an increase of $11.6 billion or 9.2% from the revised FY 2017-18 budget. The budget includes $23.4 billion in General Fund spending for the Medi-Cal program, representing a $2.6 billion or 12.6% increase compared to last fiscal year. Major Medi-Cal policies adopted in the budget include: funding from Proposition 56 tobacco tax revenue to support Medi-Cal spending growth, rate increases for home health and private duty nursing providers, funding for increased cost-sharing for ACA optional Medi-Cal expansion, county funding for outreach and treatment for homeless persons with mental illness, and expansion of Hepatitis C treatment clinical guidelines.

The budget projects $133.3 billion in General Fund revenues and transfers in FY 2018-19, an increase of $3.5 billion or 2.7% compared to last fiscal year. The three largest General Fund taxes (i.e., personal income tax, sales and use tax, corporation tax) are projected to increase by 4%. The state is projected to end FY 2018-19 with $13.8 billion in total reserves.

Patient Protection and Affordable Care Act – In March 2010, the President signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the ACA), transformed the U.S. health-care system and increased regulations within the U.S. health insurance industry. In January 2015, California expanded Medi-Cal coverage for low-income families, children, pregnant women, seniors, and persons with disabilities. For the years ended June 30, 2018 and 2017, CalOptima served an average of 240,000 and 231,000 optional Medi-Cal expansion members per month, with a decrease in revenue of approximately $14,586,000 and an increase of $88,812,000, respectively.

DHCS Annual Audit – DHCS conducted its annual audit of CalOptima's Medi-Cal program in late February and early March 2018. As of this writing, CalOptima expects to receive a draft audit report and participate in DHCS' formal exit conference in late August 2018. DHCS has not provided CalOptima with a preliminary notification of whether there are any findings associated with the audit.

Requests for Information – This financial report has been prepared in the spirit of full disclosure to provide the reader with an overview of CalOptima's operations. If the reader has questions or would like additional information about CalOptima Foundation, please direct the requests to CalOptima, 505 City Parkway West, Orange, CA 92868 or call 714.347.3237.

MOSSADAMS

Report of Independent Auditors

The Board of Directors
Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Report on Financial Statements

We have audited the accompanying consolidated statements of net position of Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima (a discrete component unit of the County of Orange, California) (CalOptima), as of June 30, 2018 and 2017 and the related consolidated statements of revenues, expenses, and changes in net position and cash flows for the years ended June 30, 2018 and 2017, and the related notes to the consolidated financial statements, which collectively comprise CalOptima's basic consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of CalOptima as of June 30, 2018 and 2017, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 3 to the consolidated financial statements, in the years ended June 30, 2018 and June 30, 2017, CalOptima adopted new accounting guidance, GASB Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other than Pensions*. Our opinion is not modified with respect to this matter. The consolidated statement of net position as of June 30, 2017 and the related consolidated statement of revenues, expenses, and change in net position for the year ended June 30, 2017 have been restated to show the impact of the adoption of GASB 75.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis, schedules of changes in net pension liability and related ratios, schedule of plan contributions, and schedule of changes in total OPEB liability and related ratios, as listed in the table of contents, be presented to supplement the basic consolidated financial statements. Such information, although not a part of the basic consolidated financial statements, is required by the Governmental Accounting Standards Board, which considers it to be an essential part of financial reporting for placing the basic consolidated financial statements in an appropriate operational, economic or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods or preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic consolidated financial statements, and other knowledge we obtained during our audit of the basic consolidated financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated September 21, 2018, on our consideration of the CalOptima's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering CalOptima's internal control over financial reporting and compliance.

Moss Adams LLP

Irvine, California
September 21, 2018

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima
Consolidated Statements of Net Position

	June 30, 2018	June 30, 2017 (as restated)
CURRENT ASSETS		
Cash and cash equivalents	$ 370,932,987	$ 510,062,983
Investments	580,298,949	1,082,425,753
Premiums due from the State of California	296,371,640	522,793,705
Prepaid expenses and other	31,076,723	26,384,678
Total current assets	1,278,680,299	2,141,667,119
BOARD-DESIGNATED ASSETS AND RESTRICTED CASH		
Cash and cash equivalents	26,682,953	17,709,682
Investments	511,564,720	517,428,691
Restricted deposit	300,000	300,000
	538,547,673	535,438,373
CAPITAL ASSETS, NET	50,758,254	54,301,035
Total assets	1,867,986,226	2,731,406,527
DEFERRED OUTFLOWS OF RESOURCES		
Net pension	10,573,050	11,577,140
Other postemployment benefit	560,000	-
Total assets and deferred outflows of resources	$ 1,879,119,276	$ 2,742,983,667

See accompanying notes to the consolidated financial statements.

Back to Agenda

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima
Consolidated Statements of Net Position (continued)

	June 30, 2018	June 30, 2017 (as restated)
CURRENT LIABILITIES		
Medical claims liability and capitation payable		
Medical claims liability	$ 263,057,437	$ 426,676,745
Provider capitation and withholds	96,448,891	580,839,710
Accrued reinsurance costs to providers	3,464,488	5,681,300
Due to State of California and the Centers for Medicare and Medicaid Services (CMS)	567,116,026	845,888,193
Unearned revenue	112,557,008	102,284,235
	1,042,643,850	1,961,370,183
Accounts payable and other	8,030,637	9,723,907
Accrued payroll and employee benefits and other	10,869,839	10,101,233
Total current liabilities	1,061,544,326	1,981,195,323
POSTEMPLOYMENT HEALTH CARE PLAN	24,565,000	26,278,000
NET PENSION LIABILITY	25,100,820	15,430,763
OTHER LONG-TERM LIABILITIES	100,000	100,000
Total Liabilities	1,111,310,146	2,023,004,086
DEFERRED INFLOWS OF RESOURCES		
Net pension	1,028,380	1,340,010
Other postemployment benefit	2,301,000	-
NET POSITION		
Net investment in capital assets, net of related debt	50,637,437	54,103,912
Restricted - required tangible net equity and restricted deposit	89,037,443	98,445,479
Unrestricted	624,804,870	566,090,180
Total net position	764,479,750	718,639,571
Total liabilities, deferred inflows of resources and net position	$ 1,879,119,276	$ 2,742,983,667

See accompanying notes to the consolidated financial statements.
Back to Agenda

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Consolidated Statements of Revenues, Expenses, and Changes in Net Position

	Years Ended June 30,	
	2018	2017 (as restated)
REVENUES:		
Premium revenues	$ 3,445,699,268	$ 3,549,461,873
Other income	-	27,164
Total operating revenues	3,445,699,268	3,549,489,037
OPERATING EXPENSES:		
Medical expenses		
Provider capitation	1,068,367,719	984,437,605
Claims expense to providers and facilities	1,403,275,064	1,561,399,095
Prescription drugs	442,312,644	423,946,865
Other medical	42,215,978	49,429,921
OneCare Connect	302,761,410	355,208,384
OneCare	14,437,586	16,424,252
Pace	18,341,424	8,766,268
Total medical expenses	3,291,711,825	3,399,612,390
Administrative expenses		
Salaries, wages and employee benefits	85,386,751	69,574,654
Professional fees	2,430,578	1,241,416
Purchased services	11,460,353	11,278,918
Supplies, occupancy, insurance and other	25,070,349	22,788,692
Premium tax	-	-
Depreciation	7,499,203	6,544,639
Total administrative expenses	131,847,234	111,428,319
Total operating expenses	3,423,559,059	3,511,040,709
OPERATING INCOME	22,140,209	38,448,328
NON-OPERATING REVENUES (EXPENSES):		
Net investment income and other	21,714,051	15,766,423
Rental income, net of related expenses	1,985,919	1,957,766
Total non-operating revenues and expenses	23,699,970	17,724,189
Increase in net position	45,840,179	56,172,517
Net position, beginning of year	718,639,571	662,467,054
Net position, end of year	$ 764,479,750	$ 718,639,571

See accompanying notes to the consolidated financial statements.

Back to Agenda

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima
Consolidated Statements of Cash Flows

	Years Ended June 30, 2018	2017 (as restated)
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation payments received and other	$ 3,403,621,939	$ 3,417,382,842
Payments to providers and facilities	(3,941,938,764)	(2,945,552,284)
Payments to vendors	(45,346,595)	(39,179,989)
Payments to employees	(74,227,628)	(70,854,310)
Net cash (used in) provided by operating activities	(657,891,048)	361,796,259
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchases of capital assets	(3,956,422)	(5,850,108)
Net cash used in capital and related financing activities	(3,956,422)	(5,850,108)
CASH FLOWS FROM INVESTING ACTIVITIES		
Investment income received	28,891,325	11,823,120
Purchases of securities	(12,243,048,906)	(644,508,177)
Sales of securities	12,736,875,055	527,913,163
Net cash provided by (used in) investing activities	522,717,474	(104,771,894)
Net (decrease) increase in cash and cash equivalents	(139,129,996)	251,174,257
CASH AND CASH EQUIVALENTS, beginning of year	510,062,983	258,888,726
CASH AND CASH EQUIVALENTS, end of year	$ 370,932,987	$ 510,062,983
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating income	$ 22,140,209	$ 38,448,328
ADJUSTMENT TO RECONCILE OPERATING INCOME TO NET CASH (USED IN) PROVIDED BY OPERATING ACTIVITIES		
Depreciation	7,499,203	6,544,639
Changes in assets and liabilities		
Premiums receivable from the State of California	226,422,065	(52,530,134)
Prepaid expenses and other	(4,692,045)	(3,088,232)
Medical claims liability	(163,619,308)	274,250,196
Payable to the State of California and CMS	(278,772,167)	16,434,944
Unearned revenue	10,272,773	(96,011,005)
Provider capitation and withholds	(484,390,819)	179,013,410
Accounts payable and other	(1,693,270)	(782,731)
Accrued payroll and employee benefits and other	768,606	(1,735,957)
Accrued reinsurance costs to providers	(2,216,812)	796,500
Postemployment health-care plan	28,000	(1,049,000)
Net pension obligation	10,362,517	1,505,301
Net cash (used in) provided by operating activities	$ (657,891,048)	$ 361,796,259
SUPPLEMENTAL SCHEDULE OF NON-CASH OPERATING AND INVESTING ACTIVITIES		
Change in unrealized appreciation on investments	$ (5,492,336)	$ (1,252,325)

See accompanying notes to the consolidated financial statements.
Back to Agenda

Note 1 – Organization

Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima (CalOptima) is a county-organized health system (COHS) serving primarily Medi-Cal beneficiaries in Orange County, California. Pursuant to the California Welfare and Institutions Code, CalOptima was formed by the Orange County Board of Supervisors as a public/private partnership through the adoption of Ordinance No. 3896 in August 1992. The agency began operations in October 1995.

As a COHS, CalOptima maintains an exclusive contract with the State of California Department of Health Care Services (DHCS) to arrange for the provision of health-care services to Orange County's Med-Cal beneficiaries. Orange County had approximately 764,000 and 772,000 Medi-Cal beneficiaries for the years ended June 30, 2018 and 2017, respectively. CalOptima also offers OneCare, a Medicare Advantage Special Needs Plan, via a contract with the Centers for Medicare, and Medicaid Services (CMS). In January 2016, CalOptima began transferring subscribers from OneCare to the OneCare Connect Cal MediConnect Plan. OneCare served approximately 1,400 and 1,100 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2018 and 2017, respectively. In January 2016, CalOptima began offering OneCare Connect Cal MediConnect Plan (OCC), a Medicare-Medicaid Plan, via a contract with CMS. OCC served approximately 15,000 and 16,000 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2018 and 2017, respectively. CalOptima also contracts with the California Department of Aging to provide case management of social and health-care services to approximately 300 Medi-Cal eligible seniors under California's Multipurpose Senior Services program. The Program of All-inclusive Care for the Elderly (PACE) provides services to 55 years of age or older members who reside in the PACE service area and meet California nursing facility level of care requirements. The program receives Medicare and Medi-Cal funding.

CalOptima in turn subcontracts the delivery of health care services through health maintenance organizations and provider-sponsored organizations, known as Physician/Hospital Consortia, and Shared Risk Groups. Additionally, CalOptima has direct contracts with hospitals and providers for its fee-for service network.

CalOptima is Knox-Keene licensed for purposes of its Medicare programs and is subject to certain provisions of the Knox-Keene Act to the extent incorporated by reference into CalOptima's contract with DHCS. As such, CalOptima is subject to the regulatory requirements of the Department of Managed Health Care under Section 1300, Title 28 of the California Administrative Code of Regulations, including minimum requirements of Tangible Net Equity, which CalOptima exceeded as of June 30, 2018 and 2017.

CalOptima Foundation (the "Foundation") was formed as a not-for-profit benefit corporation in 2010 and is dedicated to the betterment of public health-care services in Orange County. CalOptima has sole control over the activities of the Foundation and as such, the activities of the Foundation are included in the consolidated financial statements of CalOptima.

Note 2 – Summary of Significant Accounting Policies

Basis of presentation – CalOptima is a county-organized health system governed by a 10-member Board of Directors appointed by the Orange County Board of Supervisors. The CalOptima Board of Directors also serves as the Board of Directors of the Foundation. Effective for the fiscal year ended June 30, 2014, CalOptima began reporting as a discrete component unit of the County of Orange, California. The County made this determination based on the County Board of Supervisors' role in appointing all members of the CalOptima Board of Directors.

Principle of consolidation – The consolidated financial statements include the accounts of CalOptima and the Foundation (collectively referred to herein as the "Organization").

Basis of accounting – CalOptima uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. The accompanying consolidated financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board (GASB).

Use of estimates – The preparation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and cash equivalents – The Organization considers all highly liquid investments with original maturities of three months or less to be cash and cash equivalents.

Investments – Investments are stated at fair value in accordance with GASB Codification Section 150. The fair value of investments is estimated based on quoted market prices, when available. For debt securities not actively traded, fair values are estimated using values obtained from external pricing services or are estimated by discounting the expected future cash flows, using current market rates applicable to the coupon rate, credit and maturity of the investments.

All investments with an original maturity of one year or less when purchased are recorded as current investments, unless designated or restricted.

Board-designated assets and restricted cash – CalOptima's Board of Directors designated the establishment of certain reserve funds for contingencies. According to CalOptima's policy, the desired level for these funds is between 1.4 months and 2 months of premium revenues. CalOptima is required to maintain a $300,000 restricted deposit as a part of the Knox-Keene Health Care Service Plan Act of 1975 (see Note 10).

Note 2 – Summary of Significant Accounting Policies (continued)

Capital assets – Capital assets are stated at cost at the date of acquisition. The costs of normal maintenance, repairs and minor replacements are charged to expense when incurred.

Depreciation is calculated using the straight-line method over the estimated useful lives of the assets. Long-lived assets are periodically reviewed for impairment. The following estimated useful lives are used:

	Years
Furniture	5 years
Vehicles	5 years
Computers and software	3 years
Leasehold improvements	15 years or life of lease, whichever is less
Building	40 years
Building components	10 to 30 years
Land improvements	8 to 25 years
Tenant improvements	7 years or life of lease, whichever is less

Fair value of financial instruments – The consolidated financial statements include financial instruments for which the fair market value may differ from amounts reflected on a historical basis. Financial instruments of the Organization consist of cash deposits, investments, premium receivable, accounts payable, and certain accrued liabilities. The Organization's other financial instruments generally approximate fair market value based on the relatively short period of time between origination of the instruments and their expected realization.

Medical claims liability and expenses – CalOptima establishes a claims liability based on estimates of the ultimate cost of claims in process and a provision for incurred but not yet reported (IBNR) claims, which is actuarially determined based on historical claim payment experience and other statistics. Such estimates are continually monitored and analyzed with any adjustments made as necessary in the period the adjustment is determined. CalOptima retains an outside actuary to perform an annual review of the actuarial projections. Amounts for claims payment incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled.

Note 2 – Summary of Significant Accounting Policies (continued)

Provider capitation and withholds – CalOptima has provider services agreements with several health networks in Orange County, whereby the health networks provide care directly to covered members or through subcontracts with other health care providers. Payment for the services provided by the health networks is on a fully capitated basis. The capitation amount is based on contractually agreed-upon terms with each health network. CalOptima withholds amounts from providers at an agreed-upon percentage of capitation payments made to ensure the financial solvency of each contract. CalOptima also records a liability related to quality incentive payments and risk-share provisions. The quality incentive liability is estimated based on member months and rates agreed upon by the Board of Directors. For the risk-share provision liability, management allocates surplus or deficits, multiplied by a contractual rate, with the shared-risk groups. Estimated amounts due to health networks pertaining to risk-share provisions were approximately $44,660,000 and $532,665,000 as of June 30, 2018 and 2017, respectively. During the years ended June 30, 2018 and 2017, CalOptima incurred approximately $1,212,059,000 and $1,096,426,000, respectively, of capitation expense relating to health care services provided by health networks. Capitation expense is included in the provider capitation and OneCare line items in the consolidated statements of revenues, expenses and changes in net position. Estimated amounts due to health networks as of June 30, 2018 and 2017, related to the capitation withhold arrangements, quality incentive payments, and risk-share provisions were approximately $96,449,000 and $580,840,000, respectively.

Premium deficiency reserves – CalOptima performs periodic analyses of its expected future health care costs and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is accrued. Investment income is not included in the calculation to estimate premium deficiency reserves. CalOptima's management determined that no premium deficiency reserves were necessary as of June 30, 2018 and 2017.

Accrued compensated absences – CalOptima's policy permits employees who are regularly scheduled to work more than 20 hours per week to accrue 18 days of paid time off (PTO) (23 days for exempt employees) based on their years of continuous service, with an additional week of accrual after three years of service and another after 10 years of service. Unused PTO may be carried over into subsequent years, not to exceed two and a half times the annual accrual. If an employee reaches his/her PTO maximum accrual, a portion of the accrued PTO equal to half of the employees' annual PTO accruals will be automatically paid out to the employees. Accumulated PTO will be paid to the employees upon separation from service with CalOptima. All compensated absences are accrued and recorded in accordance with GASB Codification Section C60, and are included in accrued payroll and employee benefits.

Note 2 – Summary of Significant Accounting Policies (continued)

Net position – Net position is reported in three categories, defined as follows:

- **Net investment in capital assets** – This component of net position consists of capital assets, including restricted capital assets, net of accumulated depreciation, and is reduced by the outstanding balances of any bonds, notes or other borrowings that are attributable (if any) to the acquisition, construction or improvement of those assets.

- **Restricted** – This component of net position consists of external constraints placed on net asset use by creditors (such as through debt covenants), grantors, contributors, or the law or regulations of other governments. It also pertains to constraints imposed by law or constitutional provisions or enabling legislation (see Note 10).

- **Unrestricted** – This component of net position consists of net position that does not meet the definition of "restricted" or "net investment in capital assets, net of related debt."

Operating revenues and expenses – CalOptima's consolidated statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with arranging for the provision of health care services. Operating expenses are all expenses incurred to arrange for the provision of health care services as well as the costs of administration. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in operating expenses. Non-exchange revenues and expenses are reported as nonoperating revenues and expenses.

Revenue recognition and due to or from the State of California and CMS – Premium revenue is recognized in the period the members are eligible to receive health care services. Premium revenue is generally received from the State of California (the "State") each month following the month of coverage based on estimated enrollment and capitation rates as provided for in the State contract. As such, premium revenue includes an estimate for amounts receivable from or refundable to the State for these retrospective adjustments. These estimates are continually monitored and analyzed, with any adjustments recognized in the period when determined. OneCare premium revenue is generally received from CMS each month for the month of coverage. Premiums received in advance are recorded in unearned revenue on the consolidated statements of net position. Included in premium revenue are retroactive adjustments favorable to CalOptima in the amount of approximately $75,511,000 and $164,025,000 related to retroactive capitation rate adjustments and receipt of new information from DHCS during the years ended June 30, 2018 and 2017, respectively.

Note 2 – Summary of Significant Accounting Policies (continued)

Effective with the enrollment of the Medi-Cal expansion population per the Affordable Care Act (ACA) CalOptima is subject to DHCS requirements to meet the minimum 85% medical loss ratio (MLR) for this population. Specifically, CalOptima will be required to expend at least 85% of the Medi-Cal premium revenue received for this population on allowable medical expenses as defined by DHCS. In the event CalOptima expends less than the 85% requirement, CalOptima will be required to return to DHCS the difference between the minimum threshold and the actual allowed medical expenses. During 2018 and 2017, CalOptima expended more than 85% of the Medi-Cal premium revenue, therefore no reserve was recorded for the years ended June 30, 2018 and 2017. DHCS is in process of reconciling the fiscal years 2014 through 2016 and has provided CalOptima with the methodology and reporting instructions. Based on the updated methodology and reporting instructions made available in the current year, CalOptima recognized an additional reserve of approximately $64,293,000 related to fiscal years 2014 through 2016. This additional reserve was recorded as a reduction to premium revenues in the consolidated statements of revenues, expenses, and changes in net position to meet the 85% requirement. As of June 30, 2018 and 2017, approximately $227,362,000 and $164,875,000 was accrued. This liability is presented in the Due to State of California line item in the accompanying consolidated statements of net position.

Premium revenue and related net receivables as a percent of the totals were as follows:

	Years Ended June 30,			
	2018		2017	
Revenue	Revenue	%	Revenue	%
Medi-Cal	$ 3,093,733,298	89.8%	$ 3,143,998,722	88.6%
OneCare	15,943,378	0.5%	18,615,729	0.5%
OneCare Connect	315,219,443	9.1%	371,630,947	10.5%
PACE	20,803,149	0.6%	15,216,475	0.4%
	$ 3,445,699,268	100.0%	$ 3,549,461,873	100.0%

	As of June 30,			
	2018		2017	
Receivables	Receivables	%	Receivables	%
Medi-Cal	$ 279,765,285	94.4%	$ 506,599,613	96.9%
OneCare	414,035	0.1%	28,106	0.0%
OneCare Connect	12,791,802	4.3%	12,630,469	2.4%
PACE	3,400,518	1.1%	3,535,517	0.8%
	$ 296,371,640	100.0%	$ 522,793,705	100.0%

Note 2 – Summary of Significant Accounting Policies (continued)

Intergovernmental transfer – CalOptima entered into an agreement with DHCS and the University of California, Irvine (UCI) to receive an intergovernmental transfer (IGT) through a capitation rate increase of approximately $130,700,000 and $71,309,000 during the years ended June 30, 2018 and 2017, respectively. Under the agreement, approximately $99,600,000 and $56,891,000 of the funds that were received from the IGT were passed through to UCI and other contracted providers and organizations during the years ended June 30, 2018 and 2017, respectively. Under GASB, the amounts that will be passed through to UCI are not reported in the consolidated statements of revenues, expenses, and changes in net position or the consolidated statements of net position. CalOptima accounts for the IGT transfer for CalOptima purposes as an exchange transaction requiring funds to be expended prior to revenue recognition. The funds received in 2018 and 2017 were not yet expended for the required purpose during the years ended June 30, 2018 or 2017 as the revenue recognition criteria had not been met. CalOptima retains a portion of the IGT, which must be used to enhance provider reimbursement rates and strengthen the delivery system. A retainer in the amount of approximately $31,149,000 and $14,418,000 as of June 30, 2018 and 2017, respectively, is included in unearned revenues in the consolidated statements of net position.

Medicare Part D – CalOptima covers prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments CalOptima receives monthly from CMS and members, which are determined from its annual bid, represent amounts for providing prescription drug insurance coverage. CalOptima recognizes premiums for providing this insurance coverage ratably over the term of its annual contract. CalOptima's CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies, as well as receipts for certain discounts on brand name prescription drugs in the coverage gap represent payments for prescription drug costs for which CalOptima is not at risk.

The risk corridor provisions compare costs targeted in CalOptima's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to CalOptima or require CalOptima to refund to CMS a portion of the premiums CalOptima received. CalOptima estimates and recognizes an adjustment to premiums revenue related to these risk corridor provisions based upon pharmacy claims experience to date as if the annual contract were to terminate at the end of the reporting period. Accordingly, this estimate provides no consideration to future pharmacy claims experience. CalOptima records a receivable or payable at the contract level and classifies the amount as current or long-term in the accompanying consolidated statements of net position based on the timing of expected settlement. As of June 30, 2018 and 2017 the Part D payable balance was approximately $1,374,000 and $3,198,000, respectively and the Part D receivable balance was approximately $15,114,000 and $17,563,000, respectively.

Note 2 – Summary of Significant Accounting Policies (continued)

Income taxes – CalOptima operates under the purview of the Internal Revenue Code, Section 501(a), and corresponding California Revenue and Taxation Code provisions. As such, CalOptima is not subject to federal or state taxes on related income. The Foundation is operated as a tax-exempt organization under Section 501(c)(3) of the federal Internal Revenue Code and applicable sections of the California statutes. Accordingly, no provision for income tax has been recorded in the accompanying consolidated financial statements.

Premium taxes – Effective July 1, 2016, Senate Bill X2-2 (SB X2-2) *Managed Care Organization Tax* authorized Department of Health Care Services (DHCS) to implement a Managed Care Organization provider tax subject to approval by the federal Centers for Medicare and Medicaid Services. This approved tax structure is based on enrollment (total member months) between specified tiers that are assessed different tax rates. Using the approved structure, each MCO's total tax liability for years ended June 30, 2018 and 2017, were calculated. CalOptima recognized premium tax expense of approximately $143,156,000 and $137,975,000 in the consolidated statements of revenue, expenses, and change in net position for the years ended June 30, 2018 and 2017, respectively.

Pensions – For purposes of measuring the net pension liability and deferred outflows/inflows of resources related to pensions, and pension expense, information about the fiduciary net position of CalOptima's California Public Employees' Retirement System Plan (the "CalPERS Plan") and additions to/deductions from the Plan's fiduciary net position have been determined on the same basis as they are reported by CalPERS. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Reclassifications – Certain accounts in the prior-year financial statements have been reclassified for comparative purposes to conform with the presentation in the current-year financial statements.

Note 2 – Summary of Significant Accounting Policies (continued)

Recent accounting pronouncements – In June 2015, the GASB issued Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions* (GASB No. 75). The primary objective of this Statement is to improve accounting and financial reporting by state and local governments for postemployment benefits other than pensions (other postemployment benefits or OPEB). It also improves information provided by state and local governmental employers about financial support for OPEB that is provided by other entities. This Statement results from a comprehensive review of the effectiveness of existing standards of accounting and financial reporting for all postemployment benefits (pensions and OPEB) with regard to providing decision-useful information, supporting assessments of accountability and interperiod equity, and creating additional transparency. The Organization adopted this standard effective July 1, 2016 in the consolidated financial statements. See Note 3. The consolidated statement of net position as of June 30, 2017 and the related consolidated statement of revenues, expenses, and change in net position for the year ended June 30, 2017 have been restated to show the impact of the adoption of GASB 75.

In March 2017, the GASB issued Statement No. 85, *Omnibus 2017* (GASB No. 85). This Statement addresses a variety of topics including issues related to blending component units, goodwill, fair value measurement and application, and postemployment benefits (pensions and other postemployment benefits). This Statement also addresses the following topics of blending a component unit in circumstances in which the primary government is a business-type activity that reports in a single column for financial statement presentation, reporting amounts previously reported as goodwill and “negative” goodwill, timing of the measurement of pension or OPEB liabilities and expenditures recognized in financial statements prepared using the current financial resources measurement focus, and recognizing on-behalf payments for pensions or OPEB in employer financial statements. The pronouncement is effective for reporting periods beginning after June 15, 2017. The Organization concluded that this standard did not have a material impact on the consolidated financial statements.

Note 3 – Implementation of GASB 75 Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions

Effective July 1, 2016 CalOptima adopted GASB 75 Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions “OPEB”. Accordingly, the other postemployment benefit expense was decreased by approximately $2,308,000, for the year ended June 30, 2017 to reflect the adoption of GASB 75. In addition, a decrease in the post retirement liability of $2,308,000 and a corresponding increase in the unrestricted net position were recognized as of June 30, 2017. Refer to Note 9 for further disclosures related to GASB 75.

Note 4 – Cash and Investments

The Organization categorizes its fair value investments within the fair value hierarchy established by GAAP. The hierarchy for fair value measurements is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date.

Level 1 – Quoted prices in active markets for identical assets or liabilities

Level 2 – Inputs other than quoted prices included within Level 1 that are observable for an asset or liability, either directly or indirectly

Level 3 – Significant unobservable inputs

The following is a description of the valuation methodologies used for instruments at fair value on a recurring basis and recognized in the accompanying consolidated statements of net position, as well as the general classification of such instruments pursuant to the valuation hierarchy.

Marketable securities – Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. If quoted market prices are not available, then fair values are estimated by using pricing models, quoted prices of securities with similar characteristics, or discounted cash flows. These securities are classified within Level 2 of the valuation hierarchy. In certain cases where Level 1 or Level 2 inputs are not available, securities are classified within Level 3 of the hierarchy.

Note 4 – Cash and Investments (continued)

The following table presents the fair value measurements of assets recognized in the accompanying consolidated statements of net position measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall:

	Investment Assets at Fair Value as of June 30, 2018			
	Level 1	Level 2	Level 3	Total
U.S. treasury notes	$ 340,360,989	$ -	$ -	$ 340,360,989
U.S. agencies	-	97,566,400	-	97,566,400
Asset-backed securities	-	98,081,726	-	98,081,726
Commercial deposits	-	4,991,291	-	4,991,291
Commercial paper	-	22,564,481	-	22,564,481
Corporate bonds	-	325,476,437	-	325,476,437
Government	-	27,385,479	-	27,385,479
Mortgage-backed securities	-	60,653,460	-	60,653,460
Municipal bonds	-	109,676,060	-	109,676,060
Money mark funds	-	-	-	-
Tax Exempt	-	-	-	-
	$ 340,360,989	$ 746,395,334	$ -	$ 1,086,756,323

	Investment Assets at Fair Value as of June 30, 2017			
	Level 1	Level 2	Level 3	Total
U.S. treasury notes	$ 540,798,261	$ -	$ -	$ 540,798,261
Government	-	109,063,165	-	109,063,165
U.S. agencies	-	119,391,299	-	119,391,299
Asset-backed securities	-	97,004,215	-	97,004,215
Corporate bonds	-	451,582,267	-	451,582,267
Mortgage-backed securities	-	84,380,043	-	84,380,043
Municipal bonds	-	88,409,606	-	88,409,606
Certificates of deposit	-	55,580,933	-	55,580,933
Commercial paper	-	47,777,235	-	47,777,235
	$ 540,798,261	$ 1,053,188,763	$ -	$ 1,593,987,024

Note 4 – Cash and Investments (continued)

Cash and investments are reported in the June 30 consolidated statements of net position as follows:

	June 30, 2018	June 30, 2017
Current assets:		
Cash and cash equivalents	$ 370,932,987	$ 510,062,983
Investments	580,298,949	1,082,425,753
Board-designated assets and restricted cash:		
Cash and cash equivalents	26,682,953	17,709,682
Investments	511,564,720	517,428,691
Restricted deposit	300,000	300,000
	$ 1,489,779,609	$ 2,127,927,109

Custodial credit risk-deposits – Custodial credit risk is the risk that in the event of a bank failure the Organization may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the state law. At June 30, 2018 and 2017, no deposits were exposed to custodial credit risk, as the Organization has pledged collateral to cover the amounts.

Investments – CalOptima invests in obligations of the U.S. Treasury, other U.S. government agencies and instrumentalities, state obligations, corporate securities, money market funds, and mortgage or asset-backed securities.

Note 4 – Cash and Investments (continued)

Interest rate risk – In accordance with its annual investment policy ("investment policy"), CalOptima manages its exposure to decline in fair value from increasing interest rates by matching maturity dates to the extent possible with CalOptima's expected cash flow draws. Its investment policy limits maturities to five years, while also staggering maturities. CalOptima maintains a low-duration strategy, targeting a portfolio duration of three years or less, with the intent of reducing interest rate risk. Portfolios with low duration are less volatile because they are less sensitive to interest rate changes. As of June 30, 2018 and 2017, CalOptima's investments, including cash equivalents, had the following modified duration:

	June 30, 2018			
		Investment Maturities (In Years)		
Investment Type	Fair Value	Less Than 1	1-5	More Than 5
U.S. agencies	$ 97,566,400	$ 53,950,111	$ 43,616,289	$ -
Asset-backed securities	98,081,726	40,122,896	57,958,830	-
Corporate bonds	325,476,437	150,685,261	174,791,176	-
Government	27,385,479	11,916,356	15,469,123	-
Money market funds	-	-	-	-
Mortgage-backed securities	60,653,460	33,330,235	27,323,225	-
Municipal bonds	109,676,060	47,033,412	62,642,648	-
Tax exempt	-	-	-	-
U.S. treasury notes	340,360,989	209,773,924	130,587,065	-
Certificates of deposit	4,991,291	4,991,291	-	-
Commercial paper	22,564,481	22,564,481	-	-
Cash equivalents	335,013,724	335,013,724	-	-
Cash	1,375,213	1,375,213	-	-
		$ 910,756,904	$ 512,388,356	$ -
Accrued interest receivable	5,191,355			
	$ 1,428,336,615			

Note 4 – Cash and Investments (continued)

Investment with fair values highly sensitive to interest rate fluctuations – When interest rates fall, debt is refinanced and paid off early. The reduced stream of future interest payments diminishes the fair value of the investment. The mortgage-backed and asset-backed securities in the CalOptima portfolio are of high credit quality, with relatively short average lives that represent limited prepayment and interest rate exposure risk. CalOptima's investments include the following investments that are highly sensitive to interest rate and prepayment fluctuations to a greater degree than already indicated in the information provided above:

	June 30,	
	2018	2017
Asset-backed securities	$ 98,081,726	$ 97,004,215
Mortgage-backed securities	60,653,460	84,380,043
	$ 158,735,186	$ 181,384,258

Credit risk – CalOptima's investment policy conforms to the California Government Code as well as to customary standards of prudent investment management. Credit risk is mitigated by investing in only permitted investments. The investment policy sets minimum acceptable credit ratings for investments from the three nationally recognized rating services: Standard and Poor's Corporation (S&P), Moody's Investor Service (Moody's) and Fitch Ratings (Fitch). For an issuer of short-term debt, the rating must be no less than A-1 (S&P), P-1 (Moody's) or F-1 (Fitch), while an issuer of long-term debt shall be rated no less than an "A."

Note 4 – Cash and Investments (continued)

As of June 30, 2018, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt From Disclosure	Rating as of Year-End					
				AAA	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	$ 424,083,688	N/A	$ 424,083,688	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	140,852,307	N/A	140,852,307	-	-	-	-	-	-
Corporate bonds	267,655,812	A-	-	2,096,170	20,135,711	32,266,114	70,432,536	100,078,443	42,646,838
FRN securities	119,715,104	A-	-	47,187,008	3,581,153	7,419,691	19,960,470	22,322,066	19,244,716
Asset-backed securities	147,203,018	AAA	-	100,674,207	20,251,534	19,999,921	1,000,903	2,856,173	2,420,280
Mortgage-backed securities	60,754,477	AAA	-	60,754,477	-	-	-	-	-
Municpal bonds	65,961,981	A	-	4,807,874	38,071,549	12,515,979	9,074,505	1,006,522	485,552
Supranational	15,384,685	AAA	-	15,384,685	-	-	-	-	-
Certificates of deposit	5,053,486	A1/P1	-	5,053,486	-	-	-	-	-
Commercial paper	64,431,291	A1/P1	-	64,431,291	-	-	-	-	-
Money market mutual funds	117,240,767	AAA	-	117,240,767	-	-	-	-	-
Total	$ 1,428,336,616		$ 564,935,995	$ 417,629,965	$ 82,039,947	$ 72,201,705	$ 100,468,414	$ 126,263,204	$ 64,797,386

As of June 30, 2017, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt From Disclosure	Rating as of Year-End					
				AAA	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	$ 556,751,675	N/A	$ 556,751,675	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	165,604,426	N/A	165,604,426	-	-	-	-	-	-
Corporate bonds	383,257,883	A-	-	13,708,720	31,590,024	30,992,688	104,003,338	135,217,263	67,745,850
FRN securities	144,908,196	A-	-	45,470,984	13,985,742	6,212,772	25,873,521	37,150,063	16,215,114
Asset-backed securities	125,246,607	AAA	-	97,063,263	15,854,777	9,441,408	-	2,887,159	-
Mortgage-backed securities	84,491,487	AAA	-	83,412,108	1,079,379	-	-	-	-
Municpal bonds	63,298,591	A	-	2,566,925	27,034,118	33,210,423	-	-	487,125
Supranational	79,184,258	AAA	-	79,184,258	-	-	-	-	-
Certificates of deposit	40,642,387	A1/P1	-	40,642,387	-	-	-	-	-
Commercial paper	92,223,209	A1/P1	-	92,223,209	-	-	-	-	-
Money market mutual funds	329,498,381	AAA	-	329,498,381	-	-	-	-	-
Total	$ 2,065,107,100		$ 722,356,101	$ 783,770,235	$ 89,544,040	$ 79,857,291	$ 129,876,859	$ 175,254,485	$ 84,448,089

Note 4 – Cash and Investments (continued)

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of CalOptima's investment in a single issuer. CalOptima's investment policy limits to no more than 5 percent of the total fair value of investments in the securities of any one issuer, except for obligations of the U.S. government, U.S. government agencies or government-sponsored enterprises; and no more than 10 percent may be invested in one money market mutual fund unless approved by the governing board. The investment policy also places a limit of 35 percent of the amount of investment holdings with any one government-sponsored issuer and 5 percent of all other issuers. At June 30, 2018 and 2017, all holdings complied with the foregoing limitations. The following holdings exceeded 5 percent of the portfolio at June 30, 2018 and 2017:

		Percentage of Portfolio June 30,	
Investment Type	Issuer	2018	2017
U.S. Treasury notes	United States Treasury	30.42	26.09

Note 5 – Capital Assets

Capital assets activity during the year ended June 30, 2018 consisted of the following:

	June 30, 2017	Additions	Retirements	Transfers	June 30, 2018
Capital assets not being depreciated:					
Land	$ 5,876,002	$ -	$ -	$ -	$ 5,876,002
Construction in progress	702,535	3,956,422	-	(2,276,258)	2,382,699
	6,578,537	3,956,422	-	(2,276,258)	8,258,701
Capital assets being depreciated:					
Furniture and equipment	14,845,717	-	(1,051,408)	1,942,345	15,736,654
Computers and software	18,470,898	-	-	-	18,470,898
Land improvement	45,665	-	-	-	45,665
Leasehold improvements	5,180,145	-	-	12,335	5,192,480
Building	43,621,997	-	-	321,578	43,943,575
	82,164,422	-	(1,051,408)	2,276,258	83,389,272
Less accumulated depreciation for:					
Furniture and equipment	4,185,505	792,930	(1,051,408)	-	3,927,027
Computers and software	18,799,758	4,189,237	-	-	22,988,995
Land improvement	2,242,945	2,283	-	-	2,245,228
Leasehold improvements	2,728,056	596,209	-	-	3,324,265
Building	6,485,660	1,918,544	-	-	8,404,204
	34,441,924	7,499,203	(1,051,408)	-	40,889,719
Total depreciable assets, net	47,722,498	(7,499,203)	-	2,276,258	42,499,553
Capital assets, net	$ 54,301,035	$ (3,542,781)	$ -	$ -	$ 50,758,254

Note 5 – Capital Assets (continued)

Capital asset activity during the year ended June 30, 2017 consisted of the following:

	June 30, 2016	Additions	Retirements	Transfers	June 30, 2017
Capital assets not being depreciated:					
Land	$ 5,876,002	$ -	$ -	$ -	$ 5,876,002
Construction in progress	6,256,236	5,850,106	-	(11,403,807)	702,535
	12,132,238	5,850,106	-	(11,403,807)	6,578,537
Capital assets being depreciated:					
Furniture and equipment	10,259,595	-	(3,905,109)	8,491,231	14,845,717
Computers and software	18,470,898	-	-	-	18,470,898
Land improvement	45,665	-	-	-	45,665
Leasehold improvements	5,043,363	-	(1,112)	137,894	5,180,145
Building	40,847,315	-	-	2,774,682	43,621,997
	74,666,836	-	(3,906,221)	11,403,807	82,164,422
Less accumulated depreciation for:					
Furniture and equipment	3,156,343	1,029,162	-	-	4,185,505
Computers and software	19,668,092	3,036,775	(3,905,109)	-	18,799,758
Land improvement	2,240,662	2,283	-	-	2,242,945
Leasehold improvements	2,138,972	590,196	(1,112)	-	2,728,056
Building	4,599,439	1,886,221	-	-	6,485,660
	31,803,508	6,544,637	(3,906,221)	-	34,441,924
Total depreciable assets, net	42,863,328	(6,544,637)	-	11,403,807	47,722,498
Capital assets, net	$ 54,995,566	$ (694,531)	$ -	$ -	$ 54,301,035

Note 6 – Medical Claims Liability

Medical claims liability consisted of the following:

	June 30, 2018	2017
Claims payable or pending approval	$ 13,347,460	$ 26,870,842
Provisions for IBNR claims	249,709,977	261,801,881
Due to DHCS	-	138,004,022
	$ 263,057,437	$ 426,676,745

The cost of health-care services is recognized in the period in which care is provided and includes an estimate of the cost of services that has been incurred but not yet reported. CalOptima estimates accrued claims payable based on historical claims payments and other relevant information. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in medical claims liability. Estimates are continually monitored and analyzed, and as settlements are made or estimates adjusted, differences are reflected in current operations.

Note 6 – Medical Claims Liability (continued)

Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided.

The following is a reconciliation of the medical claims liability:

	For the Years Ended June 30,	
	2018	2017
Beginning balance	$ 426,676,745	$ 800,095,760
Incurred:		
Current	1,609,946,348	1,401,665,881
Prior	(7,371,113)	(5,602,159)
	1,602,575,235	1,396,063,722
Paid		
Current	1,541,304,218	1,568,167,854
Prior	224,890,325	201,314,883
	1,766,194,543	1,769,482,737
Ending balance	$ 263,057,437	$ 426,676,745

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately adjudicated and paid. Liabilities at any year-end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established prior reporting period liability. Negative amounts reported for incurred, related to prior years, result from claims being adjudicated and paid for amounts less than originally estimated. The year ended June 30, 2018 results included a decrease of prior year incurred of approximately $7,371,000. The year ended June 30, 2017 results included a decrease of prior year incurred of approximately $5,602,000. Original estimates are increased or decreased as additional information becomes known regarding individual claims.

The amounts accrued in Due to DHCS represent excess payments from DHCS that are primarily due to capitation payments received that do not reflect the current Medi-Cal expansion rates issued by DHCS. DHCS is in process of recouping these overpayments as of June 30, 2018, and the remaining overpayments not yet recouped is included as a Payable to the State of California on the consolidated statement of net position. During the year ended June 30, 2018, DHCS recouped approximately $636,927,000 related to dates of service of FY15 through FY17 for the Medi-Cal expansion population.

Note 7 – Defined Benefit Pension Plan

Plan description – CalOptima's defined benefit pension plan, Miscellaneous Plan of the Orange County Health Authority (the "CalPERS Plan"), provides retirement and disability benefits, annual cost-of-living adjustments, and death benefits to plan members and beneficiaries. The CalPERS Plan is part of the public agency portion of the California Public Employees Retirement Systems (CalPERS), an agent multiple-employer plan administered by CalPERS, which acts as a common investment and administrative agent for participating public employers within the state of California. A menu of benefit provisions as well as other requirements is established by state statues within the Public Employees' Retirement Law. CalOptima selects optional benefit provisions from the benefit menu by contract with CalPERS and adopts those benefits through the Board of Directors' approval. CalPERS issues a publicly available financial report that includes financial statements and required supplementary information for CalPERS. Copies of the report can be obtained from CalPERS Executive Office, 400 P Street, Sacramento, CA 95814.

Benefits provided – CalPERS provides service retirement and disability benefits, annual cost of living adjustments and death benefits to plan members, who must be public employees and beneficiaries. Benefits are based on years of credited service, equal to one full year of full time employment. Members with five years of total service are eligible to retire at age 50 with statutorily reduced benefits. All members are eligible for non-duty disability benefits after 10 years of service. The death benefit is one of the following: The Basic Death Benefit, the 1957 Survivor Benefit, or the Optional Settlement 2W Death Benefit. The cost of living adjustments for the plan are applied as specified by the Public Employees' Retirement Law.

The CalPERS Plan's provisions and benefits in effect at June 30, 2018 are summarized as follows:

Hire Date	Prior to January 1, 2013	On or after January 1, 2013
Benefit formula	2 % at 60	2% at 62
Benefit vesting schedule	5 years of service	5 years of service
Benefit payments	monthly for life	monthly for life
Retirement age	50 plus	52 plus
Monthly benefits as a % of eligible compensation	2.0% to 2.7%	1.0% to2.5%
Required employee contribution rates	7.0%	7.3%
Required employer contribution rates	8.3%	8.3%

The following is a summary of plan participants:

	June 30, 2018	June 30, 2017
Active employees	1219	1097
Retirees and beneficiaries:		
Receiving benefits	59	59
Deferred Retirement benefits:		
Terminated employees	128	45
Surviving spouses	3	3
Beneficiaries	3	3

Note 7 – Defined Benefit Pension Plan (continued)

Contributions – Section 20814(c) of the California Public Employees' Retirement Law (PERL) requires that the employer contribution rates for all public employers are determined on an annual basis by the actuary and shall be effective on the July 1 following notice of a change in the rate. The total plan contributions are determined through CalPERS' annual actuarial valuation process. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. The employer is required to contribute the difference between the actuarially determined rate and the contribution rate of employees. The average active employee contribution rate is 7.25 percent and 6.82 percent of annual pay for the years ended June 30, 2018 and 2017. The employer's contribution rate is 8.50 percent and 8.65 percent of annual payroll for the years ended June 30, 2018 and 2017, respectively.

CalOptima's net pension liability for the CalPERS Plan is measured as the total pension liability, less the pension plan's fiduciary net position. For the measurement period ended June 30, 2017 (the measurement date), the total pension liability was determined by rolling forward the June 30, 2016 total pension liability. Total pension liabilities were based on the following actuarial methods and assumptions as of June 30, 2017 and June 30, 2016, respectively:

Measurement Date	June 30, 2017
Actuarial Cost Method	Entry Age Normal
Actuarial Assumptions:	
Discount Rate	7.15%
Inflation	2.75%
Salary Increases	Varies by Entry Age and Service
Investment Rate of Return	includes Inflation
Mortality Rate Table	Derived using CalPERS' Membership data for all funds
Post Retirement Benefit Increase	Allowance Floor on Purchasing Power applies, 2.75% thereafter

The underlying mortality table was developed based on CalPERS' specific data. Pre-retirement and Post-retirement mortality rates include 5 years of projected mortality improvement using Scale AA published by the Society of Actuaries. The post-retirement mortality rates above include 20 years of projected ongoing mortality improvement using Scale BB published by the Society of Actuaries. All other actuarial assumptions used in the June 30, 2013 valuation were based on the results of an actuarial experience study for the period 1997 to 2011, including updates to salary increase mortality and retirement rates. The Experience Study report can be obtained at CalPERS' website.

Note 7 – Defined Benefit Pension Plan (continued)

Changes in the Net Pension Liability are as follows:

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2017	$ 112,464,954	$ 97,034,191	$ 15,430,763
Changes during the year:			
Service Cost	13,118,795	-	13,118,795
Interest on the total pension liability	9,136,725	-	9,136,725
Changes of benefit terms	-	-	-
Differences between expected and actual experience	632,642	-	632,642
Changes of assumptions	9,163,547	-	9,163,547
Contributions from the employer	-	5,234,582	(5,234,582)
Contributions from employees	-	5,793,911	(5,793,911)
Net investment income	-	11,496,425	(11,496,425)
Benefit payments, including refunds of employee contributions	(2,068,356)	(2,068,356)	-
Administrative expenses	-	(143,264)	143,264
Net changes during the year	29,983,353	20,313,298	9,670,055
Balance at June 30, 2018	$ 142,448,307	$ 117,347,489	$ 25,100,818

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2016	$ 96,499,544	$ 89,962,735	$ 6,536,809
Changes during the year:			
Service Cost	10,272,406	-	10,272,406
Interest on the total pension liability	7,702,198	-	7,702,198
Changes of benefit terms	-	-	-
Differences between expected and actual experience	102,384	-	102,384
Changes of assumptions	-	-	-
Contributions from the employer	-	3,787,544	(3,787,544)
Contributions from employees	-	4,951,820	(4,951,820)
Net investment income	-	498,498	(498,498)
Benefit payments, including refunds of employee contributions	(2,111,578)	(2,111,578)	-
Administrative expenses	-	(54,828)	54,828
Net changes during the year	15,965,410	7,071,456	8,893,954
Balance at June 30, 2017	$ 112,464,954	$ 97,034,191	$ 15,430,763

Note 7 – Defined Benefit Pension Plan (continued)

Discount rate and long term rate of return – The discount rate used to measure the total pension liability was 7.15% for the CalPERS Plan. To determine whether the municipal bond rate should be used in the calculation of a discount rate for each plan, CalPERS stress tested plans that would most likely result in a discount rate that would be different from the actuarially assumed discount rate. Based on the testing, none of the tested plans run out of assets. Therefore, the current 7.15 percent discount rate is adequate and the use of the municipal bond rate calculation is not necessary. The long term expected discount rate of 7.15 percent will be applied to all plans in the Public Employees Retirement Fund (PERF). The stress test results are presented in a detailed report called "GASB Crossover Testing Report" that can be obtained from the CalPERS website.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class.

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations as well as the expected pension fund cash flows. Such cash flows were developed assuming that both members and employers will make the required contributions as scheduled in all future years. Using historical returns of all the funds' asset classes, expected compound returns were calculated over the short-term (first 10 years) and the long-term (11-60 years) using a building-block approach. Using the expected nominal returns for both short-term and long-term, the present value of benefits was calculated for each fund. The expected rate of return was set by calculating the single equivalent expected return that arrived at the same present value of benefits for cash flows as the one calculated using both short-term and long-term returns. The expected rate of return was then set equivalent to the single equivalent rate calculated above and rounded down to the nearest one quarter of one percent.

Note 7 – Defined Benefit Pension Plan (continued)

The table below reflects long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation. These geometric rates of return are net of administrative expenses.

New Strategic Asset Class	Real Return Allocation	Real Return Years 1-10 (a)	Years 11+ (b)
Global Equity	47.0%	4.90%	5.38%
Global Fixed Income	19.0%	0.80%	2.27%
Inflation Sensitive	6.0%	0.60%	1.39%
Private Equity	12.0%	6.60%	6.63%
Real Estate	11.0%	2.80%	5.21%
Infrastructure and Forestland	3.0%	3.90%	5.36%
Liquidity	2.0%	-0.40%	-0.90%

(a) An expected inflation of 2.5% was used for this period
(b) An expected inflation of 3.0% was used for this period

The following presents the net pension liability of the CalPERS Plan calculated using the discount rate, as well as what the net pension liability would be if it were calculated using a discount rate that is 1 percentage point lower or 1 percentage point higher than the current rate:

	June 30, 2018		
	Discount Rate -1% 6.15%	Current Discount Rate 7.15%	Discount Rate +1% 8.15%
Net Pension Liability	$ 50,320,307	$ 25,100,820	$ 4,838,677

	June 30, 2017		
	Discount Rate -1% 6.65%	Current Discount Rate 7.65%	Discount Rate +1% 8.65%
Net Pension Liability	$ 34,792,255	$ 15,430,763	$ (159,810)

Note 7 – Defined Benefit Pension Plan (continued)

Pension expense and deferred outflows/inflows of resources related to pensions – CalOptima recognized pension expense of approximately $17,785,000 and $6,870,000 for the years ended June 30, 2018 and 2017, respectively. At June 30, 2018 and 2017, CalOptima recognized deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
June 30, 2018		
Contributions from employers subsequent to the measurement date	$ 393,907	$ -
Net differences between projected and actual earnings on plan investments	1,017,387	-
Changes in assumptions	7,795,853	1,028,380
Differences between expected and actual experiences	1,365,903	-
	$ 10,573,050	$ 1,028,380

	Deferred Outflows of Resources	Deferred Inflows of Resources
June 30, 2017		
Contributions from employers subsequent to the measurement date	$ 5,234,198	$ -
Net differences between projected and actual earnings on plan investments	5,270,171	-
Changes in assumptions	-	1,340,010
Differences between expected and actual experiences	1,072,771	-
	$ 11,577,140	$ 1,340,010

Note 7 – Defined Benefit Pension Plan (continued)

The deferred outflows of resources related to employer contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability during the year ended June 30, 2018. The net differences reported as deferred outflows of resources related to pensions will be recognized as pension expense as follows:

Years Ending June 30,	Deferred Outflows of Resources
2018	$ 1,395,041
2019	2,790,181
2020	1,869,552
2021	602,512
2022	1,469,996
Thereafter	1,023,481
	$ 9,150,763

Note 8 – Employee Benefit Plans

Deferred compensation plan – CalOptima sponsors a deferred compensation plan created in accordance with Internal Revenue Code Section 457 (the "457 Plan") under which employees are permitted to defer a portion of their annual salary until future years. CalOptima may make discretionary contributions to the 457 Plan as determined by the Board of Directors. For the years ended June 30, 2018 and 2017, no discretionary employer contributions were made.

Defined contribution plan – Effective January 1, 1999, CalOptima established a supplemental retirement plan for its employees called the CalOptima Public Agency Retirement System Defined Contribution Supplemental Retirement Plan ("PARS Plan"). All regular and limited-term employees are eligible to participate in the PARS Plan. The current PARS Plan design does not require employee contributions. CalOptima makes discretionary employer contributions to the PARS Plan as authorized by the CalOptima Board of Directors. Vesting occurs over 16 quarters of service. For the years ended June 30, 2018 and 2017, CalOptima contributed approximately $2,971,000 and $2,718,000, respectively.

Note 9 – Postemployment Health Care Plan

Plan description – CalOptima sponsors and administers a single-employer, defined benefit postemployment health care plan (the "Plan") to provide medical and dental insurance benefits to eligible retired employees and their beneficiaries. Benefit provisions are established and may be amended by the CalOptima Board of Directors.

Note 9 – Postemployment Health Care Plan (continued)

Effective January 1, 2004 CalOptima terminated postemployment health-care benefits for employees hired on or after January 1, 2004. For employees hired prior to January 1, 2004, the employee's eligibility for retiree health benefits remains similar to the eligibility requirements for the defined benefit pension plan.

During the year ended June 30, 2006, CalOptima modified the benefit offered to eligible participants, requiring participants to enroll in Medicare and specifying that CalOptima would be responsible only for the cost of Medicare supplemental coverage, subject to a cost sharing between the participant and CalOptima.

For purposes of measuring the total postemployment retirement liability, deferred outflows of resources and deferred inflows of resources related to OPEB, and OPEB expense, information about the fiduciary net position of the CalOptima's plan and additions to/deductions from the OPEB Plan's fiduciary net position have been determined on the same basis. For this purpose, benefit payments are recognized when currently due and payable in accordance with the benefit terms.

Generally accepted accounting principles require that the reported results must pertain to liability and asset information within certain defined timeframes. For this report, the following timeframes are used:

Measurement Date	June 30, 2017
Measurement Period	July 1, 2016 - June 30,2017
Valuation Date	January 1, 2018

Covered Employees – At June 30, 2017, the measurement date, the following numbers of participants were covered by the benefit terms:

	Number of Covered Participants
Inactives currently receiving benefits	67
Inactives entitled to but not yet receiving benefits	-
Active employees	81
Total	148

Note 9 – Postemployment Health Care Plan (continued)

Contributions – The contribution requirements of Plan members and CalOptima are established and may be amended by the CalOptima Board of Directors. CalOptima's contribution is based on projected pay-as-you-go financing requirements, with no additional amount to prefund benefits. CalOptima contributed $560,000, including $529,000 in premium payments for retirees and $31,000 for implied subsidies for the year ended June 30, 2018. CalOptima contributed $572,000, including $545,000 in premium payments for retirees and $27,000 for implied subsidies for the year ended June 30, 2017. The most recent actuarial report for the Plan was June 30, 2017. As of that point the actuarial accrued liability and unfunded actuarial accrued liability for benefits were approximately $24,565,000.

Actuarial assumptions – CalOptima's total postemployment retirement liability was measured as of June 30, 2017 and the total postemployment retirement liability used to calculate the total postemployment retirement liability was determined by an actuarial valuation dated June 30, 2016 that was rolled forward to determine the June 30, 2017 total postemployment retirement liability, based on the following actuarial methods and assumptions:

Salary Increases	3% per annum, in aggregate
Medical Trend	2076 Medicare - 6.5% for 2019, decreasing to an ultimate rate of 4.0% in 2076
Discount Rate	3.58% at June 30 2017, Bond Buyer 20 Index 2.85% at June 30 2016, Bond Buyer 20 Index
Mortality, Retirement, Disability, Termination	CalPERS 1997-2015 Experience Study Post-retirement mortality projection Scale MP-2017
General Inflation	2.75% per annum

Note 9 – Postemployment Health-Care Plan (continued)

Discount Rate and Long Term Rate of Return - The discount rate used to measure the total OPEB liability was 3.58 percent for June 30, 2017. There were no plan investments as such the expected long-term rate of return on investment is not applicable.

Changes in the Net OPEB Liability - Changes in the net OPEB liability were as follows:

Balance at June 30, 2017	$ 26,278,000
Changes for the year	
Service cost	1,012,000
Interest	770,000
Benefit changes	-
Actual vs. expected experience	-
Assumption changes	(2,923,000)
Contributions - employer	-
Contributions - employee	-
Net investment income	-
Benefit payments	(572,000)
Administrative Expenses	-
Net changes	(1,713,000)
Balance at June 30, 2018	$ 24,565,000

Sensitivity of the Net OPEB Liability to Changes in the Discount Rate - The following presents the net OPEB liability, as well as what the net OPEB liability would be if it were calculated using a discount rate that is 1 percentage point lower (2.58%) or 1 percentage point higher (4.58%) than the current discount rate:

	1% Decrease (2.58%)	Current Rate (3.58%)	1% Increase (4.58%)
Total OPEB Liability	$ 28,695,000	$ 24,565,000	$ 21,240,000

Sensitivity of the Net OPEB Liability to Changes in Health Care Cost Trend Rates - The following presents the net OPEB liability, as well as what the net OPEB liability would be if it were calculated using health care cost trend rates that are 1 percentage point lower or 1 percentage point higher than the current health care cost trend rates:

	1% Decrease	Current Rate	1% Increase
Total OPEB Liability	$ 20,842,000	$ 24,565,000	$ 29,287,000

Note 9 – Postemployment Health-Care Plan (continued)

For the year ended June 30, 2018, CalOptima recognized OPEB expense of approximately $1,751,000. At June 30, 2018, the reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ -	$ -
Changes in assumptions	-	2,301,000
Employer contributions made subsequent to measurement date	560,000	-
Total	$ 560,000	$ 2,301,000

Amounts reported as deferred outflows of resources and deferred inflows of resources will be recognized in OPEB expense as follows:

Year ending June 30,	Deferred Outflows/(Inflows) of Resources
2019	$ (622,000)
2020	(622,000)
2021	(622,000)
2022	(435,000)
2023	-
Thereafter	-

The required schedule of changes in total OPEB liability immediately following the notes to the consolidated financial statements presents multiyear trend information about the actuarial accrued liability for benefits.

Note 10 – Restricted Net Position

On June 28, 2000, CalOptima became a fully licensed health-care service plan under the Act, as required by statues governing the Healthy Families program. Under the Act, CalOptima is required to maintain and meet a minimum level of tangible net equity as of June 30, 2018 and 2017 of $89,037,443 and $98,455,479, respectively. As of June 30, 2018, the Organization is in compliance with its TNE requirement.

The Act further required the CalOptima maintain a restricted deposit in the amount of $300,000. Both CalOptima and the Foundation meet the requirement as of June 30, 2018 and 2017.

Note 11 – Lease Commitments

CalOptima leases office space and equipment under noncancelable, long-term operating leases, with minimum annual payments as follows:

Years Ending June 30,	Minimum Lease Payments
2019	$ 515,933
2020	531,411
2021	547,353
2022	277,721
	$ 1,872,418

Rental expense under operating leases was approximately $469,000 and $472,000 for the years ended June 30, 2018 and 2017, respectively.

Note 12 – Contingencies

Litigation – CalOptima is party to various legal actions and is subject to various claims arising in the ordinary course of business. Management believes that the disposition of these matters will not have a material adverse effect on CalOptima's financial position or results of operations.

Regulatory matters – The health-care industry is subject to numerous laws and regulations of federal, state and local governments. Violations of these laws and regulations could result in expulsion from government health-care programs together with the imposition of significant fines and penalties. Management believes that CalOptima is in compliance with fraud and abuse, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

Note 13 – Consolidating Information

The consolidating assets, deferred outflows of resources, liabilities, deferred inflows of resources and net position at June 30, 2018 are as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	$ 368,089,848	$ 2,843,139	$ -	$ 370,932,987
Investments	580,298,949	-	-	580,298,949
Capitation receivable from the State of California, net	296,371,640	-	-	296,371,640
Prepaid expenses and o her	31,076,723	-	-	31,076,723
Total current assets	1,275,837,160	2,843,139	-	1,278,680,299
BOARD-DESIGNATED ASSETS AND RESTRICTED CASH				
Cash and cash equivalents	26,682,953	-	-	26,682,953
Investments	511,564,720	-	-	511,564,720
Restricted deposit	300,000	-	-	300,000
	538,547,673	-	-	538,547,673
CAPITAL ASSETS, NET	50,758,254			50,758,254
Total assets	1,865,143,087	2,843,139	-	1,867,986,226
DEFERRED OUTFLOWS OF RESOURCES				
Net pension	10,573,050	-	-	10,573,050
Other postemployment benefit	560,000	-	-	560,000
Total assets and deferred outflows of resources	$ 1,876,276,137	$ 2,843,139	$ -	$ 1,879,119,276
LIABILITIES AND NET POSITION				
CURRENT LIABILITIES				
Medical claims liability and capitation payable				
Medical claims liability	$ 263,057,437	$ -	$ -	$ 263,057,437
Provider capitation and withholds	96,448,891	-	-	96,448,891
Accrued reinsurance costs to providers	3,464,488	-	-	3,464,488
Payable to State of California and the Centers for Medicare & Medicaid Services (CMS)	567,116,026	-	-	567,116,026
Unearned revenue	112,557,008	-	-	112,557,008
	1,042,643,850	-	-	1,042,643,850
Accounts payable and other	8,030,637	-	-	8,030,637
Accrued payroll and employee benefits and other	10,869,839	-	-	10,869,839
Total current liabilities	1,061,544,326	-	-	1,061,544,326
Postemployment heal h-care plan	24,565,000	-	-	24,565,000
Net pension liability	25,100,820	-	-	25,100,820
Other long term liabilities	100,000	-	-	100,000
Total liabilities	1,111,310,146	-	-	1,111,310,146
DEFERRED INFLOWS OF RESOURCES				
Net pension	1,028,380	-	-	1,028,380
Other postemployment benefit	2,301,000	-	-	2,301,000
NET POSITION				
Net investment in capital assets, net of related debt	50,637,437	-	-	50,637,437
Restricted - required tangible net equity and restricted deposit	89,037,443	-	-	89,037,443
Unrestricted	621,961,731	2,843,139	-	624,804,870
Total net posi ion	761,636,611	2,843,139	-	764,479,750
Total liabilities, deferred inflows of resources and net position	$ 1,876,276,137	$ 2,843,139	$ -	$ 1,879,119,276

Note 13 – Consolidating Information (continued)

The consolidating assets, deferred outflows of resources, liabilities, deferred inflows of resources and net position at June 30, 2017 (as restated) are as follows:

	CalOptima	CalOptima Foundation	Elimina ions	Consolidated
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	$ 507,169,844	$ 2,893,139	$ -	$ 510,062,983
Investments	1,082,425,753	-	-	1,082,425,753
Capita ion receivable from the State of California, net	522,793,705	-	-	522,793,705
Prepaid expenses and other	26,384,678	-	-	26,384,678
DUE FROM AFFILIATES	25,000	-	(25,000)	-
Total current assets	2,138,798,980	2,893,139	(25,000)	2,141,667,119
BOARD-DESIGNATED ASSETS AND RESTRICTED CASH				
Cash and cash equivalents	17,709,682	-	-	17,709,682
Investments	517,428,691	-	-	517,428,691
Restricted deposit	300,000	-	-	300,000
	535,438,373	-	-	535,438,373
CAPITAL ASSETS, NET	54,301,035			54,301,035
Total assets	2,728,538,388	2,893,139	(25,000)	2,731,406,527
DEFERRED OUTFLOWS OF RESOURCES				
Net pension	11,577,140	-	-	11,577,140
O her postemployment benefit	-	-	-	-
Total assets and deferred outflows of resources	$ 2,740,115,528	$ 2,893,139	$ (25,000)	$ 2,742,983,667
LIABILITIES AND NET POSITION				
CURRENT LIABILITIES				
Medical claims liability and capitation payable				
Medical claims liability	$ 426,676,745	$ -	$ -	$ 426,676,745
Provider capitation and wi hholds	580,839,710	-	-	580,839,710
Accrued reinsurance costs to providers	5,681,300	-	-	5,681,300
Payable to State of California and the Centers for Medicare & Medicaid Services (CMS)	845,888,193	-	-	845,888,193
Unearned revenue	102,284,235	-	-	102,284,235
	1,961,370,183	-	-	1,961,370,183
Accounts payable and o her	9,723,907	-	-	9,723,907
Accrued payroll and employee benefits and other	10,101,233	-	-	10,101,233
Due to affiliates	-	25,000	(25,000)	-
Total current liabilities	1,981,195,323	25,000	(25,000)	1,981,195,323
Postemployment health-care plan	26,278,000	-	-	26,278,000
Net pension liability	15,430,763	-	-	15,430,763
O her long term liabili ies	100,000	-	-	100,000
Total liabilities	2,023,004,086	25,000	(25,000)	2,023,004,086
DEFERRED INFLOWS OF RESOURCES				
Net pension	1,340,010	-	-	1,340,010
O her postemployment benefit	-	-	-	-
NET POSITION				
Net investment in capital assets, net of related debt	54,103,912	-	-	54,103,912
Restricted - required tangible net equity and restricted deposit	98,445,479	-	-	98,445,479
Unrestricted	563,222,041	2,868,139	-	566,090,180
Total net position	715,771,432	2,868,139	-	718,639,571
Total liabilities, deferred inflows of resources and net position	$ 2,740,115,528	$ 2,893,139	$ (25,000)	$ 2,742,983,667

Note 13 – Consolidating Information (continued)

The consolidating statements of revenues, expenses, and changes in net position for the year ended June 30, 2018 are as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
OPERATING REVENUES				
Premium revenues	$ 3,445,699,268	$ -	$ -	$ 3,445,699,268
Total operating revenues	3,445,699,268	-	-	3,445,699,268
OPERATING EXPENSES				
Medical expenses				
Provider capitation	1,068,367,719	-	-	1,068,367,719
Claim expense to providers and facilities	1,403,275,064	-	-	1,403,275,064
Prescription drugs	442,312,644	-	-	442,312,644
Other medical	42,215,978	-	-	42,215,978
OneCare Connect	302,761,410	-	-	302,761,410
OneCare	14,437,586	-	-	14,437,586
Pace	18,341,424	-	-	18,341,424
Total medical expenses	3,291,711,825	-	-	3,291,711,825
Administrative expenses				
Salaries, wages and employee benefits	85,386,751	-	-	85,386,751
Professional fees	2,430,578	-	-	2,430,578
Purchased services	11,460,353	-	-	11,460,353
Supplies, occupancy, insurance and other	25,045,349	25,000	-	25,070,349
Depreciation	7,499,203	-	-	7,499,203
Total administrative expenses	131,822,234	25,000	-	131,847,234
Total operating expenses	3,423,534,059	25,000	-	3,423,559,059
Operating income (loss)	22,165,209	(25,000)	-	22,140,209
NON-OPERATING REVENUES AND EXPENSES				
Net investment income and other	21,714,051	-	-	21,714,051
Rental income, net of related expenses	1,985,919	-	-	1,985,919
Total non-operating revenues and expenses	23,699,970	-	-	23,699,970
Increase in net position	45,865,179	(25,000)	-	45,840,179
NET POSITION, beginning of year	715,771,432	2,868,139	-	718,639,571
NET POSITION, end of year	$ 761,636,611	$ 2,843,139	$ -	$ 764,479,750

Note 13 – Consolidating Information (continued)

The consolidating statements of revenues, expenses, and changes in net position for the year ended June 30, 2017 (as restated) are as follows:

	CalOp ima	CalOptima Foundation	Eliminations	Consolidated
OPERATING REVENUES				
Premium revenues	$ 3,549,461,873	$ -	$ -	$ 3,549,461,873
O her income	-	80,829	(53,665)	27,164
Total operating revenues	3,549,461,873	80,829	(53,665)	3,549,489,037
OPERATING EXPENSES				
Medical expenses				
Provider capitation	984,437,605	-	-	984,437,605
Claim expense to providers and facilities	1,561,399,095	-	-	1,561,399,095
Prescription drugs	423,946,865	-	-	423,946,865
Other medical	49,429,921	-	-	49,429,921
OneCare Connect	355,208,384	-	-	355,208,384
OneCare	16,424,252	-	-	16,424,252
Pace	8,766,268	-	-	8,766,268
Total medical expenses	3,399,612,390	-	-	3,399,612,390
Administrative expenses				
Salaries, wages and employee benefits	69,574,654	53,435	(53,435)	69,574,654
Professional fees	1,241,416	-	-	1,241,416
Purchased services	11,278,918	-	-	11,278,918
Supplies, occupancy, insurance and other	22,734,822	54,100	(230)	22,788,692
Depreciation	6,544,639	-	-	6,544,639
Total administrative expenses	111,374,449	107,535	(53,665)	111,428,319
Total operating expenses	3,510,986,839	107,535	(53,665)	3,511,040,709
Operating income (loss)	38,475,034	(26,706)	-	38,448,328
NON-OPERATING REVENUES AND EXPENSES				
Net investment income and other	15,766,423	-	-	15,766,423
Rental income, net of related expenses	1,957,766	-	-	1,957,766
Total non-operating revenues and expenses	17,724,189	-	-	17,724,189
Increase in net posi ion	56,199,223	(26,706)	-	56,172,517
NET POSITION, beginning of year	659,572,209	2,894,845	-	662,467,054
NET POSITION, end of year	$ 715,771,432	$ 2,868,139	$ -	$ 718,639,571

Note 13 – Consolidating Information (continued)

The consolidating statement of cash flows for the year ended June 30, 2018 is as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
CASH FLOWS FROM OPERATING ACTIVITIES				
Capitation payments received and other	$ 3,403,621,939	$ -	$ -	$ 3,403,621,939
Payment to providers and facilities	(3,941,938,764)		-	(3,941,938,764)
Payments to vendors	(45,296,595)	(50,000)	-	(45,346,595)
Payments of premium tax	-	-	-	
Payments to employees	(74,227,628)	-	-	(74,227,628)
Net cash used in operating activities	(657,841,048)	(50,000)	-	(657,891,048)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES				
Purchases of capital assets	(3,956,422)	-	-	(3,956,422)
Net cash used in capital and related financing activities	(3,956,422)	-	-	(3,956,422)
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment income received	28,891,325	-	-	28,891,325
Purchases of securities	(12,243,048,906)	-	-	(12,243,048,906)
Sales of securities	12,736,875,055	-	-	12,736,875,055
Net cash provided by investing activities	522,717,474	-	-	522,717,474
Net decrease in cash and cash equivalents	(139 079 996)	(50 000)	-	(139 129 996)
CASH AND CASH EQUIVALENTS, beginning of year	507,169,844	2,893,139	-	510,062,983
CASH AND CASH EQUIVALENTS, end of year	$ 368 089 848	$ 2 843 139	$ -	$ 370 932 987

The consolidating statement of cash flows for the year ended June 30, 2017 is as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
CASH FLOWS FROM OPERATING ACTIVITIES				
Capitation payments received and other	$ 3,417,266,654	$ 116,188	$ -	$ 3,417,382,842
Payments to providers and facilities	(2,945,552,284)	-	-	(2,945,552,284)
Payments to vendors	(39,115,530)	(64,459)	-	(39,179,989)
Payments to employees	(70,800,875)	(53,435)	-	(70,854,310)
Net cash provided by operating activities	361,797,965	(1,706)	-	361,796,259
CASH FLOWS FROM CAPITAL AND RELATED F NANCING ACTIVITIES				
Purchases of capital assets	(5,850,108)	-	-	(5,850,108)
Net cash used in capital and related financing activities	(5,850,108)	-	-	(5,850,108)
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment income received	11,823,120	-	-	11,823,120
Purchases of securities	(644,508,177)	-	-	(644,508,177)
Sales of securities	527,913,163	-	-	527,913,163
Net cash used in investing activities	(104,771,894)	-	-	(104,771,894)
Net increase (decrease) in cash and cash equivalents	251,175,963	(1,706)	-	251,174,257
CASH AND CASH EQUIVALENTS, beginning of year	255,993,883	2,894,845	-	258,888,728
CASH AND CASH EQUIVALENTS, end of year	$ 507,169,846	$ 2,893,139	$ -	$ 510,062,985

Supplementary Information

Back to Agenda

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Schedule of Changes in Net Pension Liability and Related Ratios

	June 30,			
	2018	2017	2016	2015
Total Pension Liability				
Service Cost	$ 13,118,795	$ 10,272,406	$ 8,363,183	$ 6,464,105
Interest	9,136,725	7,702,198	6,620,025	5,661,111
Changes in Benefit Terms	-	-	-	-
Differences Between Expected and Actual Experience	9,163,547	102,384	1,444,808	-
Changes in Assumptions	632,642	-	(1,963,270)	-
Benefit Payments, Including Refunds of Employee Contr butions	(2,068,356)	(2,111,578)	(1,676,666)	(1,326,364)
Net Change in Total Pension Liability	29,983,353	15,965,410	12,788,080	10,798,852
Total Pension Liability - Beginning	112,464,954	96,499,544	83,711,464	72,912,613
Total Pension Liability - Ending	$ 142,448,307	$ 112,464,954	$ 96,499,544	$ 83,711,465
Plan Fiduciary Net Position				
Contributions - Employer	$ 5,234,580	$ 3,787,544	$ 3,033,171	$ 3,119,804
Contributions - Employee	5,793,911	4,951,820	4,142,126	3,385,296
Net Investment Income	11,496,425	498,498	1,913,380	12,062,654
Benefit Payments, Including Refunds of Employee Contrbutions	(2,068,356)	(2,111,578)	(1,676,666)	(1,326,364)
Other Changes in Fiduciary Net Position	(143,264)	(54,828)	(101,246)	-
Net Change in Fiduciary Net Position	20,313,296	7,071,456	7,310,765	17,241,390
Plan Fiduciary Net Position - Beginning	97,034,191	89,962,735	82,651,970	65,410,580
Plan Fiduciary Net Position - Ending	$ 117,347,487	$ 97,034,191	$ 89,962,735	$ 82,651,970
Plan Net Pension Liability - Ending	$ 25,100,820	$ 15,430,763	$ 6,536,809	$ 1,059,495
Plan Fiduciary Net Position as Percentage of the Total Liability	82.38%	86.28%	93.23%	98.73%
Covered-Employee Payroll	$ 80,217,654	$ 68,583,296	$ 55,676,606	$ 40,940,556
Plan Net Pension Liability as a Percentage of Covered Employee Payroll	31.29%	22.50%	11.74%	2.59%

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima
Schedule of Plan Contributions

	Years Ended June 30,			
	2018	2017	2016	2015
Actuarially Determined Contributions	$ 5,234,580	$ 3,787,544	$ 3,033,171	$ 3,119,804
Contributions in Relation To the Actuarially Determined Contribution	(5,234,580)	(3,787,544)	(3,033,171)	(3,119,804)
Contribution Deficiency (Excess)	$ -	$ -	$ -	$ -
Covered-Employee Payroll	$ 80,217,654	$ 68,583,296	$ 55,676,606	$ 40,940,556
Contributions as a Percentage of Covered-Employee Payroll	6.53%	5.52%	5.45%	7.62%

See accompanying report of independent auditors.

Back to Agenda

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

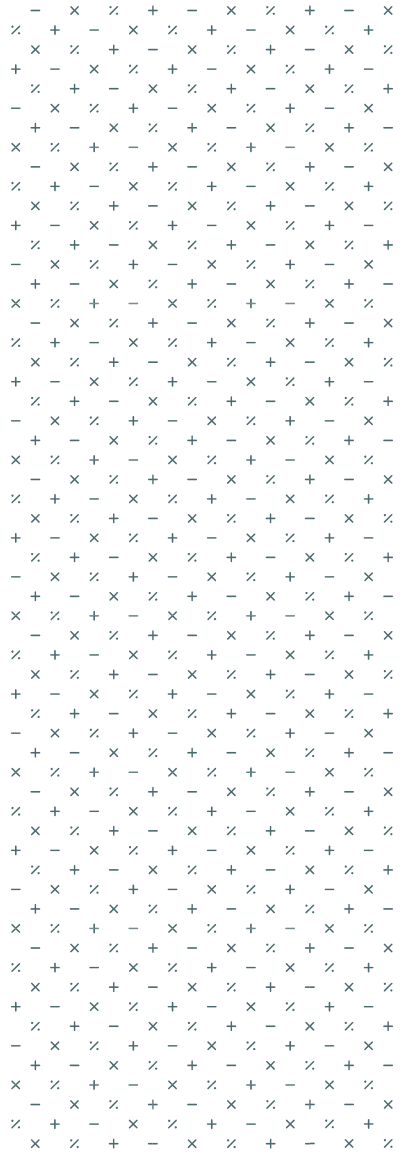
Schedule of Changes in Total OPEB Liability and Related Ratios

Changes in Total OPEB Liability	2017-2018 (Measurement Period 2016-2017)
Service cost	$ 1,012,000
Interest	770,000
Benefit changes	-
Actual vs. expected experience	-
Assumption changes	(2,923,000)
Benefit payments	(572,000)
Net changes	(1,713,000)
Total OPEB Liability (beginning of year)	26,278,000
Total OPEB Liability (end of year)	$ 24,565,000

Total OPEB Liability	$ 24,565,000
Covered employee payroll	9,135,000
Total OPEB Liability as a percentage of covered employee payroll	268.9%

MOSSADAMS

2018 Audit Results: CalOptima



Back to Agenda

Audit Committee

CalOptima

Dear Board of Directors (the “Board”):

Thank you for your continued engagement of Moss Adams LLP. We are pleased to have the opportunity to meet with you to discuss the results of our audit of the consolidated financial statements and federal program compliance of CalOptima (“the Organization”) for the year ended June 30, 2018.

The accompanying report, which is intended solely for the use of the Board and management, presents important information regarding the CalOptima’s consolidated financial statements and our audit that we believe will be of interest to you. It is not intended and should not be used by anyone other than these specified parties.

We receive the full support and assistance of the Organization’s personnel. We are pleased to serve and be associated with the Organization’s as its independent public accountants and look forward to our continued relationship.

We look forward to discussing our report or any other matters of interest with you during this meeting.

Back to Agenda

Agenda

- Auditor Opinions and Reports
- Communication with Those Charged with Governance
- Other Information

Back to Agenda

MOSSADAMS

Auditor Opinions & Reports

Better Together: Moss Adams & CalOptima

Back to Agenda

Scope of Services

We have performed the following services for CalOptima

- Annual consolidated financial statement audit as of and for the year ended June 30, 2018

We have also performed the following non-attest services:

- Assisted in the drafting the consolidated financial statements of CalOptima
- Preparation of the Form 990 for the Foundation
- Assisted in the completion of the auditee portion of the Data Collection Form

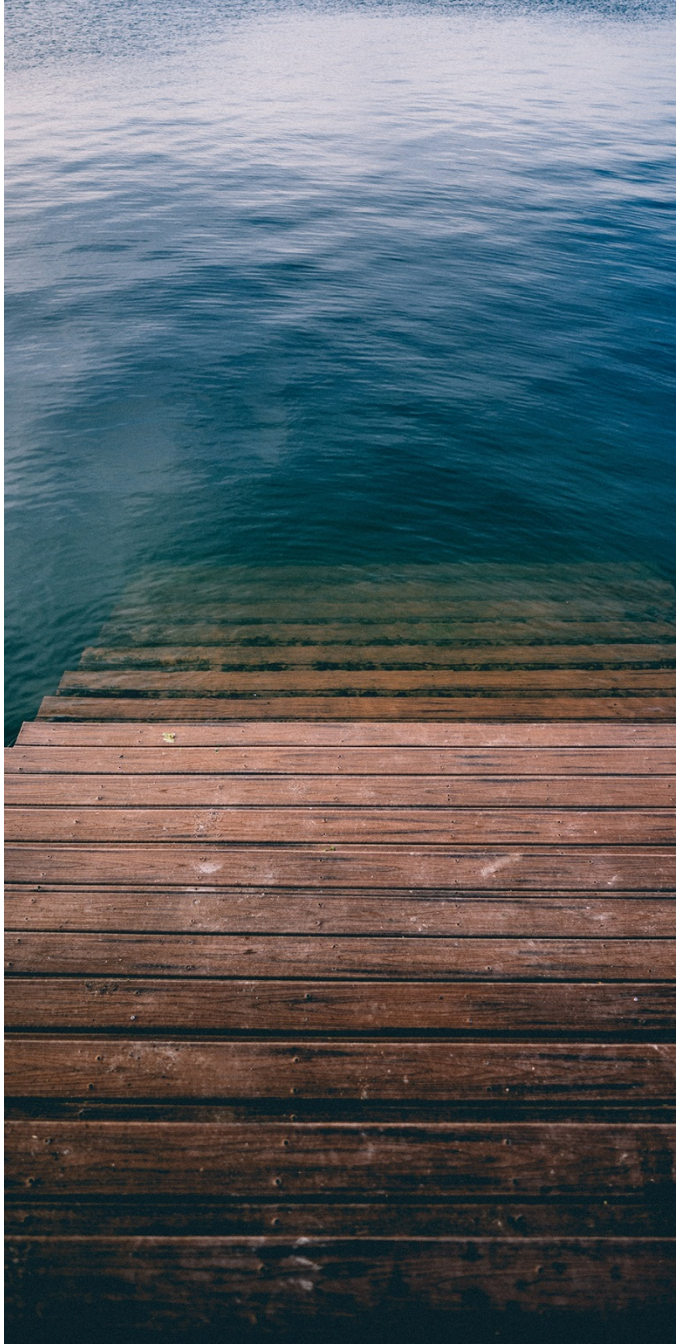
Back to Agenda

Auditor Report on the Consolidated Financial Statements

Unmodified Opinion

- Consolidated financial statements are presented fairly and in accordance with US GAAP

Back to Agenda



Other Auditor Reports

GAGAS Report on ***Internal Control Over Financial Reporting*** and on ***Compliance*** and ***Other Matters***

- No financial reporting findings reported
- No compliance findings reported

Report on Compliance with Requirements that could have a ***Direct and Material Effect on Each Major Federal Program*** and on ***Internal Control Over Compliance*** required by the ***Uniform Guidance***

- No control findings reported
- No compliance findings reported

Back to Agenda

MOSSADAMS

Communication with Board

Better Together: Moss Adams & CalOptima

Back to Agenda

COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

Our Responsibility

Our responsibility under US Generally Accepted Auditing Standards and Government Auditing Standards.

1

To express our opinion on whether the consolidated financial statements prepared by management with your oversight are fairly presented, in all material respects, and in accordance with U.S. GAAP. However, our audit does not relieve you or management of your responsibilities.

2

To perform an audit in accordance with generally accepted auditing standards issued by the AICPA, Government Auditing Standards issued by the Comptroller General of the United States, and design the audit to obtain reasonable, rather than absolute, assurance about whether the consolidated financial statements are free of material misstatement.

3

To consider internal control over financial reporting as a basis for designing audit procedures but not for the purpose of expressing an opinion on its effectiveness or to provide assurance concerning such internal control.

4

To communicate findings that, in our judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Back to Agenda

Planned Scope & Timing of the Audit

It is the auditor's responsibility to determine the overall audit strategy and the audit plan, including the nature, timing and extent of procedures necessary to obtain sufficient and appropriate audit evidence and to communicate with those charged with governance and overview of the planned scope and timing of the audit.

OUR COMMENTS

- The planned scope and timing of the audit was communicated to the CalOptima's Finance and Audit Committee at the audit entrance meeting on May 17, 2018 and was included in the engagement letter for the year ended June 30, 2018.

Back to Agenda

Significant Accounting Policies & Unusual Transactions

The auditor should determine that the audit committee is informed about the initial selection of and changes in significant accounting policies or their application. The auditor should also determine that the Board is informed about the methods used to account for significant unusual transactions and the effect of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.

OUR COMMENTS

- Management has the responsibility for selection and use of appropriate accounting policies. The significant accounting policies used by the Organization are described in the footnotes to the consolidated financial statements. Throughout the course of an audit, we review changes, if any, to significant accounting policies or their application, and the initial selection and implementation of new policies. There were no changes to significant accounting policies for the year ended June 30, 2018. CalOptima adopted GASB No. 75 effective July 1, 2016. The impact of this is described in Note 3.
- We believe management has selected and applied significant accounting policies appropriately and consistent with those of the prior year.

Back to Agenda

Management Judgements & Accounting Estimates

The Board should be informed about the process used by management in formulating particularly sensitive accounting estimates and about the basis for the auditor's conclusions regarding the reasonableness of those estimates.

OUR COMMENTS

- Management's judgements and accounting estimates are based on knowledge and experience about past and current events and assumptions about future events. We apply audit procedures to management's estimates to ascertain whether the estimates are reasonable under the circumstances and do not materially misstate the consolidated financial statements.
- Significant management estimates impacted the consolidated financial statements including the following: **fair value of investments; fixed asset lives; actuarially determined accruals for incurred but not reports (IBNR) medical claims liabilities, Non-IBNR liabilities; and pension, and other post-employment liabilities.**
- We deem them to be reasonable.

Back to Agenda

Areas of Audit Emphasis

- Medical Claims Liability and Claims Expense
- Capitation Revenue and Receivables
- Amounts due to the state of California or DHCS
- Pension liability
- OPEB liability

Back to Agenda

Management Judgements & Accounting Estimates

Our views about the quantitative aspects of the entity's significant accounting policies, accounting estimates, and financial statement disclosures.

OUR COMMENTS

- The disclosures in the consolidated financial statements are clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statements users. We call your attention to the following notes:

  - Note 2 – Summary of Significant accounting policies
  - Note 4 – Cash and Investments
  - Note 6 – Medical Claims Liability
  - Note 7 – Defined Benefit Pension Plan
  - Note 9 – Postemployment Health Care Plan

Back to Agenda

Significant Audit Adjustments & Unadjusted Differences Considered by Management to Be Immaterial

The Board should be informed of all significant audit adjustments arising from the audit. Consideration should be given to whether an adjustment is indicative of a significant deficiency or a material weakness in the CalOptima's internal control over financial reporting, or in its process for reporting interim financial information, that could cause future consolidated financial statements to be materially misstated.

The Board should also be informed of uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented that were determined by management to be immaterial, both individually and in the aggregate, to the consolidated financial statements as a whole.

OUR COMMENTS

- **There were no corrected or uncorrected audit adjustments**

Back to Agenda

Deficiencies in Internal Control

Any material weaknesses and significant deficiencies in the design or operation of internal control that came to the auditor's attention during the audit must be reported to the Board.

OUR COMMENTS

- Material weakness
  - None noted
- Significant deficiencies
  - Nothing to communicate

Back to Agenda

Potential Effect on the Consolidated Financial Statements of Any Significant Risks & Exposures

The Board should be adequately informed of the potential effect on financial statements of significant risks and exposures and uncertainties that are disclosed in the consolidated financial statements.

OUR COMMENTS

- CalOptima is subject to potential legal proceedings and claims that arise in the ordinary course of business, which are disclosed in the notes to the consolidated financial statements.

Back to Agenda

Difficulties Encountered in Performing the Audit

The Board should be informed of any significant difficulties encountered in dealing with management related to the performance of the audit, including disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the CalOptima's financial statements, or the auditor's report.

OUR COMMENTS

- No significant difficulties were encountered during our audit.
- We are pleased to report that there were no disagreements with management.

Back to Agenda

Material Uncertainties Related to Events & Conditions/ Fraud & Noncompliance with Laws and Regulations

Any doubt regarding the entity's ability to continue, as a going concern, should be communicated to the Board.

Fraud involving senior management and fraud (whether caused by senior management or other employees) that causes a material misstatement of the consolidated financial statements should be communicated. We are also required to communicate any noncompliance with laws and regulations involving senior management that come to our attention, unless clearly inconsequential.

OUR COMMENTS

- No such matters came to our attention.
- We have not become aware of any instances of fraud or noncompliance with laws and regulations.

Back to Agenda

Other Material Written Communications

The Board should be informed of any significant difficulties encountered in dealing with management related to the performance of the audit, including disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the CalOptima's consolidated financial statements, or the auditor's report.

OUR COMMENTS

- We have requested certain representations from management that will be included in the representation letter, which we will receive prior to issuance.
- Other than the engagement letter, management representation letter, and communication to those charged with governance, there have been no other significant communications.

Back to Agenda

Management's Consultation with Other Accountants

In some cases, management may decide to consult about auditing and accounting matters. If management has consulted with other accountants about an auditing and accounting matter that involves application of an accounting principle to the CalOptima's consolidated financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts.

OUR COMMENTS

- We are not aware of any significant accounting or auditing matters for which management consulted other accountants.

Back to Agenda

Devon Wiens, Partner
DeVon.Wiens@mossadams.com
(949) 221-4060

Aparna Venkateswaran, Senior Manager
Aparna.Venkateswaran@mossadams.com
(949) 517-9473

THANK YOU

Back to Agenda

CALOPTIMA FOUNDATION BOARD ACTION AGENDA REFERRAL

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

Report Item
6. Consider Accepting and Receiving and Filing the Fiscal Year 2018 CalOptima Foundation Audited Financial Statements

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

Recommended Action
Recommend accepting and receiving and filing the Fiscal Year (FY) 2018 CalOptima Foundation audited financial statements as submitted by independent auditors Moss-Adams, LLP.

Background
Moss-Adams has been contracted to audit the financial statements of the CalOptima Foundation since May 21, 2015 and has prepared a FY 2018 Audit Plan. The plan included performing the mandatory annual consolidated financial statement audit, and the drafting of the consolidated financial statements for the year ending June 30, 2018.

Discussion
Moss-Adams performed the interim audit from May 21, 2018 through May 25, 2018, and the year-end on-site audit from July 23, 2018, through August 17, 2018.

Results from the CalOptima Foundation's FY 2018 Audit were positive. The auditor made no changes in the Foundation's approach to applying the critical accounting policies and did not report having encountered any significant difficulties during the audit. Additionally, there were no material misstatements identified by the auditor. As such, Management recommends that the Foundation Board to accept the CalOptima Foundation FY 2018 audited financial statements as presented.

Fiscal Impact
There is no fiscal impact related to this recommended action.

Concurrence
Gary Crockett, Chief Counsel
CalOptima Foundation Audit Committee

Attachments
1. FY 2018 CalOptima Foundation Audited Financial Statements
2. Presentation by Moss Adams, LLP

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

Back to Agenda

REPORT OF INDEPENDENT AUDITORS AND FINANCIAL STATEMENTS WITH REQUIRED SUPPLEMENTARY FINANCIAL INFORMATION

CALOPTIMA FOUNDATION

June 30, 2018 and 2017

MOSSADAMS

Back to Agenda

Table of Contents

Back to Agenda

Introduction

CalOptima Foundation (the "Foundation") is a not-for-profit organization and foundation established by Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima ("CalOptima") in June 2010. It was formed for the benefit of CalOptima members and others in the Orange County community. One of the primary objectives for the Foundation is to take advantage of health related programs and funding opportunities that are not available to governmental entities. Other planned activities are focused on addressing unmet community needs and increasing provider capacity.

The following discussion and analysis of the Foundation's financial statements presents an overview of the financial position and activities as of June 30, 2018 and 2017. This discussion has been prepared by management and should be read in conjunction with the accompanying financial statements and related notes.

Using the Financial Statements

The Foundation's annual report contains three financial statements: the statement of net position, the statement of revenues, expenses and changes in net position, and the statement of cash flows. The report was prepared using the accrual basis of accounting. These statements provide information on the Foundation as a whole and present the Foundation's financial position and results of operations. In the opinion of management, the financial statements represent accurately the financial situation of the Foundation as of June 30, 2018 and 2017. The various components of the financial statements document financial position of the Foundation and its ability to meet its financial obligations as they come due.

Financial Highlights

The Foundation was formed in June 2010. The total assets and liabilities as of June 30, 2018 and 2017 were $2,843,139 and $2,893,139, respectively.

CalOptima's senior management continue to investigate potential future grant making and program development opportunities that would improve the overall health of CalOptima's members.

Statements of Net Position

The statements of net position are point-in-time financial statements. The purpose of these statements is to present a fiscal snapshot of the Foundation to the readers of the financial statements at June 30, 2018 and 2017. The statements of net position include year-end information concerning current and noncurrent assets, current and noncurrent liabilities, and net position (assets less liabilities). Current assets and liabilities include other assets and obligations that can reasonably expect to be sold, collected, consumed or paid within 12 months of the date of the statement. The statements also present the available assets that can be used to satisfy those liabilities.

The following table summarizes the Foundation's assets, liabilities and net position as of June 30, 2018 and June 30, 2017:

	2018	2017
Current assets	$ 2,843,139	$ 2,893,139
Total assets	$ 2,843,139	$ 2,893,139
Current liabilities	$ -	$ 25,000
Net position	2,843,139	2,868,139
Total liabilities and net position	$ 2,843,139	$ 2,893,139

Statements of Revenues, Expenses and Changes in Net Position

Changes in net position as presented on the statements of net position are based on the activity presented in the statements of revenues, expenses and changes in net position. The purpose of the statements is to present the revenue earned by the Foundation, both operating and nonoperating, and the expenses incurred by the Foundation, both operating and nonoperating, and any other revenues, expenses, gains and losses earned or incurred by the Foundation.

The following table summarizes the Foundation's revenues, expenses and changes in net position for the years ended June 30:

	2018	2017	2016
Revenues:			
Operating revenues			
Grant revenue	$ -	$ 27,164	$ 304,593
Contributions	-	53,665	348,730
Total revenues	-	80,829	653,323
Operating expenses	25,000	107,535	665,082
Change in net position	(25,000)	(26,706)	(11,759)
Net position:			
Beginning	2,868,139	2,894,845	2,906,604
Ending	$ 2,843,139	$ 2,868,139	$ 2,894,845

Statements of Revenues, Expenses and Changes in Net Position (continued)

Operating revenues – For the years ended June 30, 2018, 2017 and 2016, operating revenues totaled $0, $80,829, and $653,323, respectively. The revenues are from HITECH grant activities and contributions from CalOptima. CalOptima provided $0, $53,665, and $348,730, respectively, of staff services that are recognized as non-exchange transactions for the years ended June 30, 2018, 2017, and 2016.

Operating expenses – For the years ended June 30, 2018, 2017 and 2016, operating expenses totaled $25,000, $107,535, and $665,082, respectively. The expenses from the HITECH grant activities include staff services, miscellaneous supplies, and travel.

Economic Factors That May Affect the Future

In 2010, the Foundation was awarded the HITECH grant with projected total revenues in excess of $6.6 million over four years. As of June 30, 2018, the Foundation did not receive any funding as a part of the HITECH grant, with finalization of remaining funding completed early in fiscal 2017.

Requests for Information

This financial report has been prepared in the spirit of full disclosure to provide the reader with an overview of CalOptima Foundation's operations. If the reader has questions or would like additional information about CalOptima Foundation, please direct the request to CalOptima Foundation, 505 City Parkway West, Orange, CA 92868 or call 714.347.3237.

MOSSADAMS

Report of Independent Auditors

The Board of Directors
CalOptima Foundation

Report on the Financial Statements

We have audited the accompanying statements of net position of CalOptima Foundation (the "Foundation"), a component unit of the Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima, as of June 30, 2018 and 2017 and the related statements of revenues, expenses, and changes in net position and cash flows for the years ended June 30, 2018 and 2017, and the related notes to the consolidated financial statements, which collectively comprise the Foundation's basic financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinions

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the governmental activities, the business-type activities, the aggregate discretely presented component units, each major fund, and the aggregate remaining fund information of the Foundation as of June 30, 2018 and 2017, and the respective changes in financial position and, where applicable, cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 1 through 3 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Moss Adams LLP

Irvine, California
September 21, 2018

CalOptima Foundation
Statements of Net Position

ASSETS	June 30, 2018	June 30, 2017
CURRENT ASSETS		
Cash	$ 2,843,139	$ 2,893,139
Total assets	$ 2,843,139	$ 2,893,139
LIABILITIES AND NET POSITION		
CURRENT LIABILITIES		
Payable to CalOptima	$ -	$ 25,000
Total liabilities	-	25,000
UNRESTRICTED NET POSITION	2,843,139	2,868,139
Total liabilities and net position	$ 2,843,139	$ 2,893,139

See accompanying notes.

Back to Agenda

CalOptima Foundation
Statements of Revenues, Expenses, and Changes in Net Position

	Years Ended June 30,	
	2018	2017
OPERATING REVENUES		
Grant revenue	$ -	$ 27,164
Total operating revenues	-	27,164
OPERATING EXPENSES		
Salaries, wages, and employee benefits	-	53,435
Supplies and other	25,000	54,100
Total operating expenses	25,000	107,535
Operating loss	(25,000)	(80,371)
NON-OPERATING REVENUES		
Contributions	-	53,665
Total nonoperating revenues	-	53,665
Change in net position	(25,000)	(26,706)
NET POSITION		
Beginning	2,868,139	2,894,845
Ending	$ 2,843,139	$ 2,868,139

See accompanying notes.

Back to Agenda

CalOptima Foundation
Statements of Cash Flows

	Years Ended June 30, 2018	Years Ended June 30, 2017
CASH FLOWS FROM OPERATING ACTIVITIES		
Grant payments and contributions received	$ -	$ 62,523
Payments to vendors	(50,000)	(64,459)
Payments to employees	-	230
Net cash used in operating activities	(50,000)	(1,706)
Net change in cash	(50,000)	(1,706)
Cash		
Beginning	2,893,139	2,894,845
Ending	$ 2,843,139	$ 2,893,139
RECONCILIATION OF OPERATING LOSS TO NET CASH USED IN OPERATING ACTIVITIES		
Operating loss	$ (25,000)	$ (80,371)
Contributions	-	53,665
Adjustments to reconcile operating loss to net cash used in operating activities:		
Changes in assets and liabilities		
Grant receivables	-	35,359
Accounts payable	-	(35,298)
Payable to CalOptima	(25,000)	24,939
Net cash used in operating activities	$ (50,000)	$ (1,706)

See accompanying notes.

Back to Agenda

Note 1 – Nature of Operations, Reporting Entity and Significant Accounting Policies

Nature of operations – CalOptima Foundation (the Foundation) is a nonprofit organization formed in June 2010 in the state of California. The operations of the Foundation include, but are not limited to, applying for and administering grants dedicated to the betterment of public health-care services. The Foundation is organized and operated exclusively to benefit Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima ("CalOptima") program needs.

Reporting entity – The Foundation has no component units, but is a component unit of CalOptima because the Foundation's governing body is the same as the governing body of CalOptima. The financial statements present only the Foundation, and do not purport to, and do not present, the financial position of CalOptima as of June 30, 2018 and 2017, or the changes in its financial position, or its cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

Basis of accounting – The financial statements of the Foundation have been prepared using the economic resource management focus and the accrual basis of accounting. Revenues are recognized when earned, and expenses and liabilities are recognized when incurred.

The Foundation considers grant revenues earned as operating revenue. Expenses associated with managing the grant and the Foundation are considered operating expenses. All revenues and expenses not meeting this definition are reported as nonoperating revenues and expenses.

Net position – Net position represents the difference between assets and liabilities. Net position is reported as restricted if there are limitations imposed on their use. When an expense is incurred for purposes for which both restricted and unrestricted net positions are available, the Foundation first applies restricted resources. The Foundation had no restricted net position at June 30, 2018 or 2017.

Revenue recognition – Grant revenue and contributions are recorded as earned over the period covered in accordance with the grant provisions.

Income tax status – The Internal Revenue Service has recognized the Foundation as exempt from federal and state income tax on related income under Section 501(c)(3) of the Internal Revenue Code. The Foundation is not classified as a private foundation. The Foundation has reviewed its tax positions for all open tax years and has concluded that no liabilities exist as of June 30, 2018 and 2017. The Foundation files tax returns with the U.S. federal and the State of California jurisdictions.

Note 2 – Cash and Custodial Credit Risk

As of June 30, 2018 and 2017, all cash deposits held with financial institutions were insured by the Federal Deposit Insurance Corporation and through securities pledged by the financial institutions held in an individual collateral pool by a depository regulated under California state law.

Note 3 – Related-Party Transactions

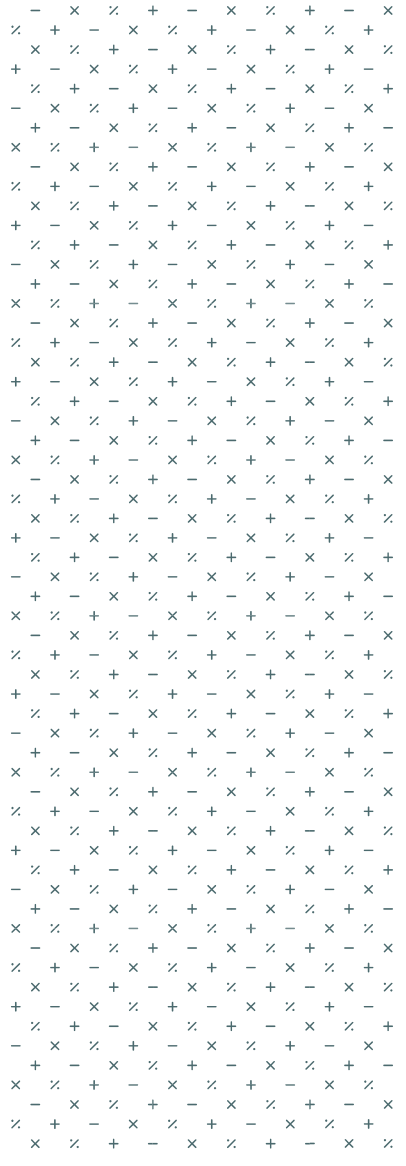
CalOptima provides certain services for the benefit of the Foundation at no charge. The cost of the services provided by CalOptima is reported as in-kind income and expenses by the Foundation. These services include, but are not limited to: staff compensation, travel, equipment and supplies. Total contributions from CalOptima were $0 and $53,655 for the years ended June 30, 2018 and 2017, respectively. As of June 30, 2018 and 2017, the Foundation had recorded payables to CalOptima of $0 and $25,000, respectively.

Note 4 – Grant Revenue

The Foundation was awarded a four-year HITECH grant on September 26, 2010, plus a one-year post-award amendment effective until September 26, 2015. During the year ended June 30, 2016, the Foundation received an additional one-year post-award amendment, which extended the award to September 26, 2016. This grant is for the Foundation to assist Orange County health-care providers with adopting and implementing electronic health records. The Foundation is responsible for enrolling 1,000 providers as well as project management of multiple phases of demonstrating meaningful use. Grant income is recognized when qualifying expenditures have been incurred and upon achievement of other criteria. Recipients of the HITECH grant are required to meet a 10 percent match in proportion to the expenditures of the federal share of the total project costs. CalOptima provides this match through in-kind contributions. The funds from the HITECH grant were fully expended during the year ended June 30, 2017.

MOSSADAMS

2018 Audit Results: CalOptima Foundation



Back to Agenda

Audit Committee

Dear Foundation Board of Directors (the"Board):

Thank you for your continued engagement of Moss Adams LLP. We are pleased to have the opportunity to meet with you to discuss the results of our audit of the financial statements of CalOptima Foundation ("the Foundation") for the year ended June 30, 2018.

The accompanying report, which is intended solely for the use of the Board and management, presents important information regarding the Foundation's financial statements and our audit that we believe will be of interest to you. It is not intended and should not be used by anyone other than these specified parties.

We receive the full support and assistance of the Foundation's personnel. We are pleased to serve and be associated with the Foundation as its independent public accountants and look forward to our continued relationship.

We look forward to discussing our report or any other matters of interest with you during this meeting.

Back to Agenda

Agenda

- Auditor Opinion and Report
- Communication with Those Charged with Governance
- Other Information

Back to Agenda

MOSSADAMS

Auditor Opinion & Report

Better Together: Moss Adams & CalOptima Foundation

Back to Agenda

Scope of Services

We have performed the following services for CalOptima Foundation:

- Annual financial statement audit as of and for the year ended June 30, 2018

We have also performed the following non-attest services:

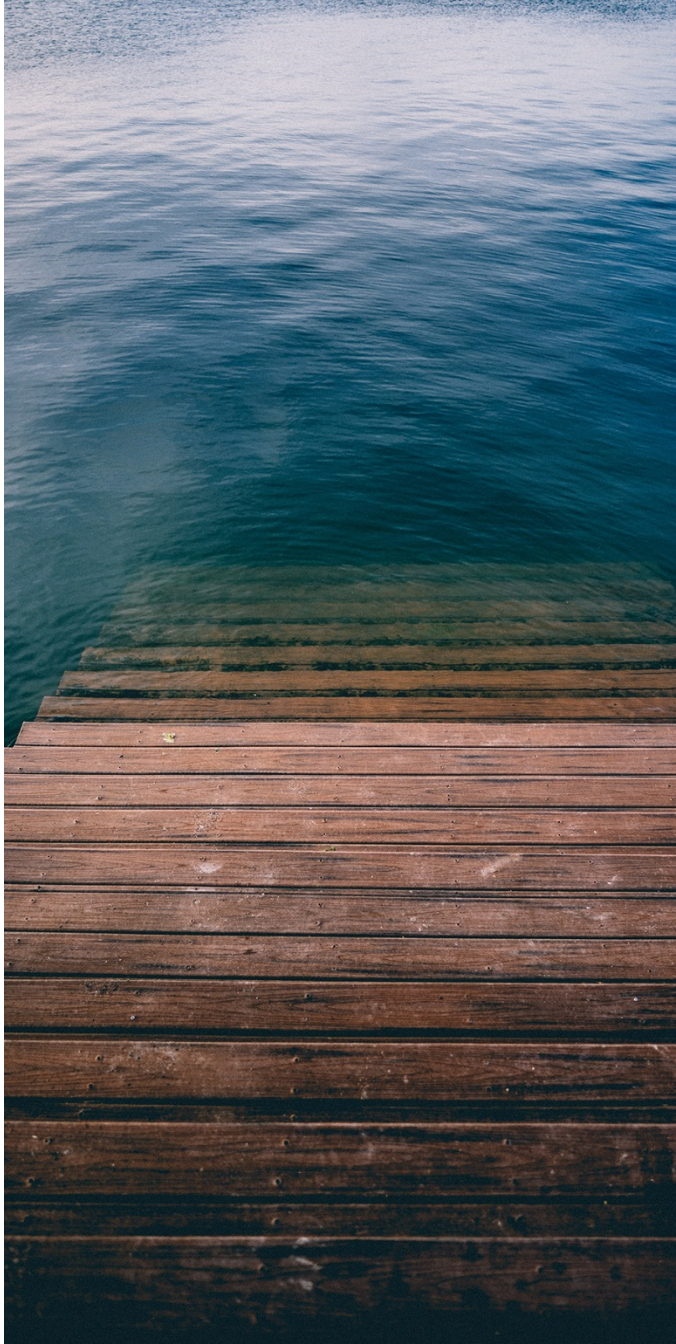
- Assisted in the drafting the consolidated financial statements of the Foundation
- Preparation of the Form 990 for the Foundation

Back to Agenda

Auditor Report on the Financial Statements

Unmodified Opinion

- Financial statements are presented fairly and in accordance with US GAAP



Back to Agenda

MOSSADAMS

Communication with the Board

Better Together: Moss Adams & CalOptima Foundation

Back to Agenda

COMMUNICATION WITH FAC

Our Responsibility

Our responsibility under US Generally Accepted Auditing Standards

1

To express our opinion on whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, and in accordance with U.S. GAAP. However, our audit does not relieve you or management of your responsibilities.

2

To perform an audit in accordance with generally accepted auditing standards issued by the AICPA, and design the audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement.

3

To consider internal control over financial reporting as a basis for designing audit procedures but not for the purpose of expressing an opinion on its effectiveness or to provide assurance concerning such internal control.

4

To communicate findings that, in our judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Back to Agenda

COMMUNICATION WITH THE BOARD

Planned Scope & Timing of the Audit

It is the auditor's responsibility to determine the overall audit strategy and the audit plan, including the nature, timing and extent of procedures necessary to obtain sufficient and appropriate audit evidence and to communicate with those charged with governance and overview of the planned scope and timing of the audit.

OUR COMMENTS

- The planned scope and timing of the audit was communicated to the Foundation's FAC at the audit entrance meeting on May 17, 2018.

Back to Agenda

COMMUNICATION WITH BOARD

Significant Accounting Policies & Unusual Transactions

The auditor should determine that the Board is informed about the initial selection of and changes in significant accounting policies or their application. The auditor should also determine that the Board is informed about the methods used to account for significant unusual transactions and the effect of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.

OUR COMMENTS

- Management has the responsibility for selection and use of appropriate accounting policies. The significant accounting policies used by the Foundation are described in the footnotes to the financial statements. Throughout the course of an audit, we review changes, if any, to significant accounting policies or their application, and the initial selection and implementation of new policies. There are no changes to significant accounting policies for the year ended June 30, 2018.
- We believe management has selected and applied significant accounting policies appropriately and consistent with those of the prior year.

Back to Agenda

Management Judgements & Accounting Estimates

The Board should be informed about the process used by management in formulating particularly sensitive accounting estimates and about the basis for the auditor's conclusions regarding the reasonableness of those estimates.

OUR COMMENTS

- Management's judgements and accounting estimates are based on knowledge and experience about past and current events and assumptions about future events. We apply audit procedures to management's estimates to ascertain whether the estimates are reasonable under the circumstances and do not materially misstate the financial statements.
- No significant estimates noted.

Back to Agenda

COMMUNICATION WITH BOARD

Areas of Audit Emphasis

- Cash

Back to Agenda

Management Judgements & Accounting Estimates

Our views about the quantitative aspects of the entity's significant accounting policies, accounting estimates, and financial statement disclosures.

OUR COMMENTS

- The disclosures in the financial statements are clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statements users. We call your attention to the following notes:
    - Note 1 – Nature of operations, Reporting Entity and Significant Accounting Policies

Back to Agenda

Significant Audit Adjustments & Unadjusted Differences Considered by Management to Be Immaterial

The Board should be informed of all significant audit adjustments arising from the audit. Consideration should be given to whether an adjustment is indicative of a significant deficiency or a material weakness in the Foundation's internal control over financial reporting, or in its process for reporting interim financial information, that could cause future financial statements to be materially misstated.

The Board should also be informed of uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented that were determined by management to be immaterial, both individually and in the aggregate, to the financial statements as a whole.

OUR COMMENTS

There were no corrected or uncorrected audit adjustments.

Back to Agenda

COMMUNICATION WITH BOARD

Deficiencies in Internal Control

Any material weaknesses and significant deficiencies in the design or operation of internal control that came to the auditor's attention during the audit must be reported to the Board.

OUR COMMENTS

- Material weakness
  - None noted
- Significant deficiencies
  - Nothing to communicate

Back to Agenda

Potential Effect on the Financial Statements of Any Significant Risks & Exposures

The Board should be adequately informed of the potential effect on financial statements of significant risks and exposures and uncertainties that are disclosed in the financial statements.

OUR COMMENTS

- The Foundation is subject to potential legal proceedings and claims that arise in the ordinary course of business, which are disclosed in the notes to the financial statements.

Back to Agenda

COMMUNICATION WITH BOARD

Difficulties Encountered in Performing the Audit

The Board should be informed of any significant difficulties encountered in dealing with management related to the performance of the audit, including disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the Foundation's financial statements, or the auditor's report.

OUR COMMENTS

- No significant difficulties were encountered during our audit.
- We are pleased to report that there were no disagreements with management.

Back to Agenda

Material Uncertainties Related to Events & Conditions/ Fraud & Noncompliance with Laws and Regulations

Any doubt regarding the entity's ability to continue, as a going concern, should be communicated to the Board.

Fraud involving senior management and fraud (whether caused by senior management or other employees) that causes a material misstatement of the financial statements should be communicated. We are also required to communicate any noncompliance with laws and regulations involving senior management that come to our attention, unless clearly inconsequential.

OUR COMMENTS

- No such matters came to our attention.
- We have not become aware of any instances of fraud or noncompliance with laws and regulations.

Back to Agenda

Other Material Written Communications

The Board should be informed of any significant difficulties encountered in dealing with management related to the performance of the audit, including disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the Foundation's financial statements, or the auditor's report.

OUR COMMENTS

- We have requested certain representations from management that will be included in the representation letter, which we will receive prior to issuance.
- Other than the engagement letter, management representation letter, and communication to those charged with governance, there have been no other significant communications.

Back to Agenda

Management's Consultation with Other Accountants

In some cases, management may decide to consult about auditing and accounting matters. If management has consulted with other accountants about an auditing and accounting matter that involves application of an accounting principle to the Foundation's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts.

OUR COMMENTS

- We are not aware of any significant accounting or auditing matters for which management consulted other accountants.

Back to Agenda

DeVon Wiens, Partner
Devon.Wiens@mossadmas.com
(949) 221-4060

Aparna Venkateswaran, Senior Manager
Aparna.Venkateswarn@mossadams.com
(949) 517-9473

THANK YOU

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

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

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

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

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

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

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

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

Back to Agenda

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

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

/s/ Michael Schrader — *9/26/2018*

Authorized Signature — **Date**

Back to Agenda

Policy #:	FF.1007~~ 2017 2018~~
Title:	**Health Network Reinsurance Coverage**
Department:	Finance
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	07/01/10
Last Review Date:	~~07~~09/~~01~~06/~~17~~18
Last Revised Date:	~~07~~09/~~01~~06/~~17~~18

I. PURPOSE

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

II. POLICY

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

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

~~B.~~C. The coverage period for this policy is each CalOptima fiscal year beginning ~~12:01~~12:00 a.m. Pacific Standard Time (PST~~),~~) July 1~~, 2017,~~ through ~~12:00 a.m.~~11:59 p.m. PST~~,~~ June 30~~, 2018~~.

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

~~D.~~E. An eligible Health Network shall submit reinsurance claims to CalOptima no later than December 31~~, 2018~~ following the end of the previous fiscal year to be eligible for reimbursement:

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

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

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

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

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

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

1. Covered hospital expenses are either:

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

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

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

2. Covered physician expenses are either:

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

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

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

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

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

1. Hospital services:

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

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

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

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

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

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

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

2. Physician services:

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

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

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

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

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

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

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

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

1. Hospital Deductible:

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

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

2. Physician Deductible:

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

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

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

III. PROCEDURE

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

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

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

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

3. Reinsurance claims shall include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. ATTACHMENTS

A. Reinsurance Field Names and Values for Electronic File Transmission

V. REFERENCES

A. Contract for Health Care Services
B. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group
C. CalOptima Policy FF.1007_~~2016~~ 2017-2018: Health Network Reinsurance Coverage
D. CalOptima Policy FF.1010: Shared Risk Pool
E. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
F. CalOptima Policy FF.3001: Financial Reporting
G. Title 42, United States Code, Section 1396u-2(b)(2)(D)
H. This policy supersedes:
   1. CalOptima Financial Bulletin #7: Policy FF.1101: Excess Risk Liability Program
   2. CalOptima Financial Bulletin #32: Revisions to FF.1200: Health Network Reinsurance Coverage
   3. CalOptima Financial Bulletin #34: Revisions to FF.1200: Health Network Reinsurance Coverage
   4. CalOptima Financial Bulletin #35: Health Network Reinsurance Program for SPD over Age 45

VI. REGULATORY AGENCY APPROVALS

A. 08/06/15: Department of Health Care Services
B. 12/10/10: Department of Health Care Services

VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 06/01/17: Regular Meeting of the CalOptima Board of Directors ~~Regular CalOptima Board of Directors Meeting~~
~~B.~~C. 10/01/09: Regular Meeting of the CalOptima Board of Directors ~~Regular CalOptima Board of Directors Meeting~~
~~C.~~D. 09/17/09: Special Meeting of the CalOptima Board of Directors' Finance Committee
~~D.~~E. 09/04/08: ~~Reg~~Regular Meeting of the CalOptima Board of Directors ~~ular CalOptima Board of Directors Meeting~~
~~E.~~ 09/11/07: Regular Meeting of the CalOptima Board of Directors ~~Regular CalOptima Board of Directors Meeting~~
F.
~~F.~~

VIII. REVIEW/REVISION HISTORY

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

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

IX. GLOSSARY

Term	Definition
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Care Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Deductible	For purposes of this policy, the amount set forth in Section III.I of this policy, which the eligible Health Network must pay in eligible expenses on behalf of a Member during the coverage period, before CalOptima is responsible for reimbursing the eligible Health Network eighty percent (80%) of eligible expenses for that Member.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.

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

1

Policy #:	FF.1007
Title:	**Health Network Reinsurance Coverage**
Department:	Finance
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	07/01/10
Last Review Date:	09/06/18
Last Revised Date:	09/06/18

I. PURPOSE

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

II. POLICY

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

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

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

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

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

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

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

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

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

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

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

1. Covered hospital expenses are either:

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

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

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

2. Covered physician expenses are either:

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

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

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

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

I. Covered expenses are subject to the following limitations:

1. Hospital services:

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

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

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

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

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

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

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

2. Physician services:

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

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

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

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

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

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

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

J. Annual Deductibles are as follows:

1. Hospital Deductible:

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

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

2. Physician Deductible:

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

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

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

III. PROCEDURE

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

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

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

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

3. Reinsurance claims shall include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. ATTACHMENTS

A. Reinsurance Field Names and Values for Electronic File Transmission

V. REFERENCES

A. Contract for Health Care Services
B. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group
C. CalOptima Policy FF.1007_2017-2018: Health Network Reinsurance Coverage
D. CalOptima Policy FF.1010: Shared Risk Pool
E. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
F. CalOptima Policy FF.3001: Financial Reporting
G. Title 42, United States Code, Section 1396u-2(b)(2)(D)
H. This policy supersedes:
    1. CalOptima Financial Bulletin #7: Policy FF.1101: Excess Risk Liability Program
    2. CalOptima Financial Bulletin #32: Revisions to FF.1200: Health Network Reinsurance Coverage
    3. CalOptima Financial Bulletin #34: Revisions to FF.1200: Health Network Reinsurance Coverage
    4. CalOptima Financial Bulletin #35: Health Network Reinsurance Program for SPD over Age 45

VI. REGULATORY AGENCY APPROVALS

A. 08/06/15: Department of Health Care Services
B. 12/10/10: Department of Health Care Services

VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
B. 06/01/17: Regular Meeting of the CalOptima Board of Directors
C. 10/01/09: Regular Meeting of the CalOptima Board of Directors
D. 09/17/09: Special Meeting of the CalOptima Board of Directors' Finance Committee
E. 09/04/08: Regular Meeting of the CalOptima Board of Directors
F. 09/11/07: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

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

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

1

IX. GLOSSARY

Term	Definition
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Care Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Deductible	For purposes of this policy, the amount set forth in Section III.I of this policy, which the eligible Health Network must pay in eligible expenses on behalf of a Member during the coverage period, before CalOptima is responsible for reimbursing the eligible Health Network eighty percent (80%) of eligible expenses for that Member.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.

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

1

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

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

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

CEO Approval: Michael Schrader _____

Effective Date: 07/01/08
Last Review Date: 05/01/1709/06/18
Last Revised Date: 05/01/1709/06/18

I. PURPOSE

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

II. POLICY

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

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

C. Effective January 1, 2019, Members who are eligible for services under the California Children's Services (CCS) Program shall not qualify for risk adjustment under this Policy.

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

1. Has an Aged, Blind, Disabled, or Temporary Assistance for Needy Families (TANF) Aid Code;

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

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

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

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

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

III. PROCEDURE

A. Risk Assignment Database

Back to Agenda

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

    a. Member identification number;

    b. Aid Code;

    c. Diagnosis code; and

    d. Procedure codes.

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

    a. Inpatient services;

    b. Outpatient services; and

    c. Physician services.

B. Calculation of Member's Risk Score

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

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

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

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

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

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

C. Calculation of Health Network Risk Factor

1. A Health Network's raw risk factor is the weighted average of all Risk Scores for Members assigned to that Health Network at a defined time.

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

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

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

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

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

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

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

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

D. Calculation of HRA Capitation Payment

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

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

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

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

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

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

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	07/01/2008	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	07/01/2009	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	09/01/2014	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	06/01/2016	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	05/01/2017	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	09/06/2018	FF.1009	Health ~~B~~-based Risk Adjusted Capitation Payment System	Medi-Cal

IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a member is eligible to receive Medi-Cal Covered Services.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in CalOptima Policy DD.2006.
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
Chronic Illness and Disability Payment System (CDPS)	A diagnostic classification system that Medicaid programs utilize to make health-based capitated payments for Temporary Assistance to Needy Families (TANF) and disabled Medicaid beneficiaries.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Health Network Risk Factor	The weighted average of all Member Risk Scores for Members assigned to that Health Network at a defined time, normalized across all Health Networks to ensure that the aggregate total Capitation Payments to all Health Networks is budget neutral to CalOptima.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Member Risk Score	A measurement of a Member's health status according to a minimum of one (1) diagnostic code.
Payment Period	For the purpose of this policy, payment period refers to a set interval of time in which CalOptima provides payment to Health Networks for Covered Services furnished to Members.

Term	Definition
Risk Assignment Database	A database that contains Members' diagnostic and medical information as reported on the facility and professional Encounter data submitted by a Health Network in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and claims data collected by CalOptima for CalOptima Direct and Shared Risk Groups.
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

1

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

CEO Approval: Michael Schrader _____

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

I. PURPOSE

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

II. POLICY

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

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

C. Effective January 1, 2019, Members who are eligible for services under the California Children's Services (CCS) Program shall not qualify for risk adjustment under this Policy.

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

1. Has an Aged, Blind, Disabled, or Temporary Assistance for Needy Families (TANF) Aid Code;

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

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

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

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

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

III. PROCEDURE

A. Risk Assignment Database

Back to Agenda

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

    a. Member identification number;

    b. Aid Code;

    c. Diagnosis code; and

    d. Procedure codes.

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

    a. Inpatient services;

    b. Outpatient services; and

    c. Physician services.

B. Calculation of Member's Risk Score

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

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

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

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

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

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

C. Calculation of Health Network Risk Factor

1. A Health Network's raw risk factor is the weighted average of all Risk Scores for Members assigned to that Health Network at a defined time.

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

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

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

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

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

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

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

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

D. Calculation of HRA Capitation Payment

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

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

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

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

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

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

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	07/01/2008	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	07/01/2009	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	09/01/2014	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	06/01/2016	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	05/01/2017	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	09/06/2018	FF.1009	Health-based Risk Adjusted Capitation Payment System	Medi-Cal

IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a member is eligible to receive Medi-Cal Covered Services.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in CalOptima Policy DD.2006.
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
Chronic Illness and Disability Payment System (CDPS)	A diagnostic classification system that Medicaid programs utilize to make health-based capitated payments for Temporary Assistance to Needy Families (TANF) and disabled Medicaid beneficiaries.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Health Network Risk Factor	The weighted average of all Member Risk Scores for Members assigned to that Health Network at a defined time, normalized across all Health Networks to ensure that the aggregate total Capitation Payments to all Health Networks is budget neutral to CalOptima.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Member Risk Score	A measurement of a Member's health status according to a minimum of one (1) diagnostic code.
Payment Period	For the purpose of this policy, payment period refers to a set interval of time in which CalOptima provides payment to Health Networks for Covered Services furnished to Members.

Term	Definition
Risk Assignment Database	A database that contains Members' diagnostic and medical information as reported on the facility and professional Encounter data submitted by a Health Network in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and claims data collected by CalOptima for CalOptima Direct and Shared Risk Groups.
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

1

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

CEO Approval: Michael Schrader _____

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

I. PURPOSE

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

II. POLICY

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

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

C. The Shared Risk Budget shall include:

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

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

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

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

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

~~D.~~E. Shared Risk Expenses shall include:

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

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

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

Back to Agenda

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

~~E.~~F. Shared Risk Expenses shall not include:

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

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

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

1. Quarter Ending September 30: Due November 15.

2. Quarter Ending December 31: Due February 15.

3. Quarter Ending March 31: Due May 15.

4. Quarter Ending June 30: Due August 15.

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

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

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

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

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

2. After issuance of the final Annual Shared Risk Program Report, if CalOptima determines that the Shared Risk Pool is in deficit, CalOptima shall carry forward an amount equal to sixty

percent (60%) of that deficit into the next fiscal year's semi-annual and/or annual reconciliation, along with any additional deficits carried forward from the previous annual settlement, except as otherwise established in the Contract for Health Care Services.

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

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

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

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

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

~~N.~~O. If a Health Network identifies an overpayment of a semi-annual or annual settlement payment, the Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima's Accounting Department in writing of the reason for the overpayment. CalOptima shall coordinate with the Health Network on the process to return the overpayment.

III. PROCEDURE

A. Quarterly Shared Risk Pool Reporting

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

2. The report shall include:

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

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

B. Semi-Annual Shared Risk Pool Reconciliation and Settlement

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

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

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

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

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

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

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

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

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

C. Annual Shared Risk Pool Reconciliation and Settlement

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

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

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

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

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

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

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

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

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

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

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

c. Shared Risk Expenses shall not include:

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Shared Risk Pool Settlement upon Termination

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

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

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

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

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

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

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

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

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

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

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

c. Shared Risk Expenses shall not include:

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

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

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

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

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

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

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

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

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

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

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

IV. ATTACHMENTS

A. Risk Pool Claims Objection Form

V. REFERENCES

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

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

VI. REGULATORY AGENCY APPROVALS

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

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	07/01/2008	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2009	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2010	FF.1010	Shared Risk Pool	Medi-Cal
Revised	09/01/2014	FF.1010	Shared Risk Pool	Medi-Cal
Revised	08/01/2016	FF.1010	Shared Risk Pool	Medi-Cal
Revised	05/01/2017	FF.1010	Shared Risk Pool	Medi-Cal
Revised	09/06/2018	FF.1010	Shared Risk Pool	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae.
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Cared Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
Contracted CalOptima Hospital	A hospital that has entered into a CalOptima Hospital Services Contract to provide hospital services to CalOptima Direct Members.
Coordination of Benefits (COB)	A method for determining the order of payment for medical or other care/treatment benefits where the primary health plan pays for covered benefits as it would without the presence of a secondary health plan.
Corrective Action Plan (CAP)	A plan delineating specific and identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the State, or designated representatives. Health Networks and Providers may be required to complete a CAP to ensure that they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
High Cost Exclusion Item	Specific high-cost items that are excluded from a Contracted Hospital's outpatient reimbursement or inpatient per diem rate.
Hospital Budget Capitation Allocation	The amount equal to the Hospital Risk Pool Capitation (PMPM) set forth in the contract multiplied by the number of Members assigned to the Shared Risk Physician.
Incurred But Not Reported (IBNR)	IBNR means "incurred but not reported," and refers to an estimate of claims that have been incurred for medical services provided, but for which claims have not yet been received by the Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.

Term	Definition
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Shared Risk Budget	The total amount that CalOptima allocates to the Shared Risk Pool to pay for Shared Risk Services set forth in the DOFR of the contract.
Shared Risk Expenses	Includes: Amounts paid for Shared Risk Services provided to Members assigned to the Shared Risk Group; An estimate of Incurred But Not Reported (IBNR) expenses; Administrative expenses at a rate established in the Contract for Health Care Services; and Any reinsurance premiums paid by CalOptima allocable to the Shared Risk Group.
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.
Shared Risk Pool	The risk sharing program, under which the risk for the provision of Shared Risk Services to Members is shared and allocated between CalOptima and the contracted Health Network.

1

Policy #:	FF.1010
Title:	**Shared Risk Pool**
Department:	Finance
Section:	Accounting
CEO Approval:	Michael Schrader _____
Effective Date:	07/01/08
Last Review Date:	09/06/18
Last Revised Date:	09/06/18

I. PURPOSE

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

II. POLICY

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

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

C. The Shared Risk Budget shall include:

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

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

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

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

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

E. Shared Risk Expenses shall include:

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

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

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

Back to Agenda

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

F. Shared Risk Expenses shall not include:

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

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

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

1. Quarter Ending September 30: Due November 15.

2. Quarter Ending December 31: Due February 15.

3. Quarter Ending March 31: Due May 15.

4. Quarter Ending June 30: Due August 15.

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

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

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

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

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

2. After issuance of the final Annual Shared Risk Program Report, if CalOptima determines that the Shared Risk Pool is in deficit, CalOptima shall carry forward an amount equal to sixty

percent (60%) of that deficit into the next fiscal year's semi-annual and/or annual reconciliation, along with any additional deficits carried forward from the previous annual settlement, except as otherwise established in the Contract for Health Care Services.

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

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

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

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

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

O. If a Health Network identifies an overpayment of a semi-annual or annual settlement payment, the Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima's Accounting Department in writing of the reason for the overpayment. CalOptima shall coordinate with the Health Network on the process to return the overpayment.

III. PROCEDURE

A. Quarterly Shared Risk Pool Reporting

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

2. The report shall include:

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

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

B. Semi-Annual Shared Risk Pool Reconciliation and Settlement

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

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

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

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

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

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

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

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

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

C. Annual Shared Risk Pool Reconciliation and Settlement

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

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

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

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

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

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

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

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

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

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

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

c. Shared Risk Expenses shall not include:

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

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

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

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

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

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

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

any deficits carried forward from the previous annual settlement. CalOptima shall retain the balance of the Shared Risk Pool.

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

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

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

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

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

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

D. Shared Risk Pool Settlement upon Termination

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

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

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

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

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

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

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

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

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

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

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

c. Shared Risk Expenses shall not include:

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

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

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

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

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

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

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

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

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

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

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

IV. ATTACHMENTS

A. Risk Pool Claims Objection Form

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

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

VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	07/01/2008	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2009	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2010	FF.1010	Shared Risk Pool	Medi-Cal
Revised	09/01/2014	FF.1010	Shared Risk Pool	Medi-Cal
Revised	08/01/2016	FF.1010	Shared Risk Pool	Medi-Cal
Revised	05/01/2017	FF.1010	Shared Risk Pool	Medi-Cal
Revised	09/06/2018	FF.1010	Shared Risk Pool	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae.
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Cared Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
Contracted CalOptima Hospital	A hospital that has entered into a CalOptima Hospital Services Contract to provide hospital services to CalOptima Direct Members.
Coordination of Benefits (COB)	A method for determining the order of payment for medical or other care/treatment benefits where the primary health plan pays for covered benefits as it would without the presence of a secondary health plan.
Corrective Action Plan (CAP)	A plan delineating specific and identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the State, or designated representatives. Health Networks and Providers may be required to complete a CAP to ensure that they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
High Cost Exclusion Item	Specific high-cost items that are excluded from a Contracted Hospital's outpatient reimbursement or inpatient per diem rate.
Hospital Budget Capitation Allocation	The amount equal to the Hospital Risk Pool Capitation (PMPM) set forth in the contract multiplied by the number of Members assigned to the Shared Risk Physician.
Incurred But Not Reported (IBNR)	IBNR means "incurred but not reported," and refers to an estimate of claims that have been incurred for medical services provided, but for which claims have not yet been received by the Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.

Term	Definition
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Shared Risk Budget	The total amount that CalOptima allocates to the Shared Risk Pool to pay for Shared Risk Services set forth in the DOFR of the contract.
Shared Risk Expenses	Includes: Amounts paid for Shared Risk Services provided to Members assigned to the Shared Risk Group; An estimate of Incurred But Not Reported (IBNR) expenses; Administrative expenses at a rate established in the Contract for Health Care Services; and Any reinsurance premiums paid by CalOptima allocable to the Shared Risk Group.
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.
Shared Risk Pool	The risk sharing program, under which the risk for the provision of Shared Risk Services to Members is shared and allocated between CalOptima and the contracted Health Network.

1

Hospital Shared Risk Pool
Shared Risk Group: _____
Risk Pool Period
Date of Service: _____
Date of Payment: _____

Line Of Business
- ☐ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect

Item #	Payment Question/Issue	CalOptima Claim No.	Member Name	Provider Name	Start Date of Service	End Date of Service	Amount Paid	Date of Payment	Requested Credit	CalOptima Review	2nd Level CalOptima GARS Appeal Review	CalOptima Potential Claim Overpayment
							$ -		$ -			$ -

Back to Agenda

Policy #:	FF.4000
Title:	**Whole-Child Model – Financial Reimbursement for Capitated Health Networks**
Department:	Finance
Section:	Accounting
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/19
Last Review Date:	Not applicable
Last Revised Date:	Not applicable

I. PURPOSE

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

II. POLICY

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

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

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

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

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

1. Initial Capitation Payments;

2. Interim catastrophic payment; and

3. Retrospective risk corridor settlements.

F. The WCM payment timelines are:

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

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

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

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

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

III. PROCEDURE

A. Initial Capitation Payment

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

2. CalOptima shall process the initial Capitation Payment in accordance with CalOptima Policy FF.1001: Capitation Payments. CalOptima shall issue one (1) payment that

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

B. Interim Catastrophic Reimbursement

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

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

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

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

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

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

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

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

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

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

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

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

        WCMReimb@caloptima.org

        Or by U.S. mail to:

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

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

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

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

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

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

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

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

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

    b. $150,000 for covered hospital expenses.

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

C. Retrospective Risk Corridor

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

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

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

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

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

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

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

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

e. Administrative and medical management components of CCS reimbursement will be adjusted based on the actual payout amount at previously established percentage.

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

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

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

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

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

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Policy FF.1001: Capitation Payments

VI. REGULATORY AGENCY APPROVALS

A. None to Date

VII. BOARD ACTIONS

A. TBD: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

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

IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Capitation Rate	The per capita rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age, and gender.
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Cared Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members enrolled to that Health Network.

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

Recommended Actions

Approve provider payment methodology for the CalOptima Medi-Cal Whole-Child Model (WCM) program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

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

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

Back to Agenda

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

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

Discussion

DHCS Capitation Rates

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

Projected Medical Costs

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

Provider Payment Model

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

CalOptima Direct Networks (COD/CCN)

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

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

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

Back to Agenda

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

Delegated Health Networks (HMO/PHC/SRG)
To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. To develop the initial capitation rate, CalOptima will employ the following methods:

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

CalOptima recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, CalOptima will implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases and (2) Retrospective risk corridor.

Back to Agenda

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

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

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

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

Back to Agenda

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

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

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

Fiscal Impact

Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

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

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *7/25/2018*

Authorized Signature — **Date**

Back to Agenda

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 7, 2018

ALL PLAN LETTER 18-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE WHOLE CHILD MODEL PROGRAM

SUBJECT: CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL PROGRAM

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide direction to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 04-0618,[1] which provides direction and guidance to county CCS programs on requirements pertaining to the implementation of the WCM program.

BACKGROUND:
Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties.[2] The purpose of the WCM program is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. MCPs operating in WCM counties will integrate Medi-Cal managed care and county CCS Program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.[3, 4]

MCPs will authorize care that is consistent with CCS Program standards and provided by CCS-paneled providers, approved special care centers, and approved pediatric acute care hospitals. The WCM program will support active participation by parents and families of CCS-eligible members and ensure that members receive protections such as

[1] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[2] SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
[3] See Health and Safety Code (HSC) Section 123850(b)(1), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=123850.
[4] See Welfare and Institutions Code (WIC) Section 14094.11, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

continuity of care (COC), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning no sooner than July 1, 2018. Upon determination by DHCS of the MCPs' readiness to address the needs of the CCS-eligible members, MCPs must transition CCS-eligible members into their MCP network of providers by their scheduled implementation date as follows:

MCP	COHS Counties
Phase 1 – No sooner than July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
Phase 2 – No sooner than January 1, 2019	
CalOptima	Orange
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo

POLICY:
Starting no sooner than July 1, 2018, MCPs in designated counties shall assume full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services, including service authorization activities, claims processing and payment, case management, and quality oversight.

Under the WCM, the MCP, county CCS program, and DHCS will each bear responsibility for various administrative functions to support the CCS Program. Responsibilities for the CCS Program's eligibility functions under the WCM are determined by whether the county CCS program operates as an independent or dependent county.[5] Independent CCS counties will maintain responsibility for CCS Program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS Program medical eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS will continue to maintain responsibility for CCS Program medical eligibility determinations and redeterminations, while the county CCS programs will maintain responsibility for financial and residential eligibility determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical

[5] A link to the Division of Responsibility chart can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

Back to Agenda

redetermination and other medical determinations, as needed, for the CCS-eligible member.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS Program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage (OHC), with full scope Medi-Cal as payor of last resort.

The implementation of WCM does not impact the activities and functions of the Medical Therapy Program (MTP) and Pediatric Palliative Care Waiver (PPCW). WCM counties participating with the MTP and PPCW will continue to receive a separate allocation for these programs. The MCP is responsible for care coordination of services that remain carved-out of the MCP's contractual responsibilities.

MCPs are required to use all current and applicable CCS Program guidelines, including CCS Program regulations, additional forthcoming regulations related to the WCM program, CCS Numbered Letters (N.L.s),[6] and county CCS program information notices, in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations and contractual requirements.

I. MCP AND COUNTY COORDINATION

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members. A quarterly meeting between the MCP and the county CCS program must be established to assist with overall coordination by updating policies, procedures, and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding (MOU) and other WCM related matters.

A. Memorandum of Understanding

MCPs and county CCS programs must execute a MOU outlining their respective responsibilities and obligations under the WCM using the MOU template posted on the CCS WCM page of the DHCS website.[7] The purpose of the MOU is to explain how the MCPs and county CCS programs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP will serve as the primary vehicle for ensuring

[6] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[7] A link to the MOU template can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

collaboration between the MCP and county CCS program. The MOU can be customized based on the needs of the individual county CCS program and the MCP, consistent with the requirements of SB 586 and dependent upon DHCS approval. The MOU must include, at a minimum, all of the provisions specified in the MOU template. Phase 1 MCPs must have submitted an executed MOU, or proved intent and/or progress made towards an executed MOU, by March 31, 2018. Phase 2 MCPs must submit an executed MOU, or prove intent and/or progress made toward an executed MOU, by September 28, 2018. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS beneficiaries into managed care for treatment of their CCS-eligible conditions. The transition plan must describe collaboration between the MCP and the county CCS program on the transfer of case management, care coordination, provider referrals, and service authorization administrative functions from the county CCS program to the MCPs.[8] The transition plan must also include communication with beneficiaries regarding, but not limited to, authorizations, provider network, case management, and ensuring continuity of care and services for beneficiaries in the process of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

C. Inter-County Transfer

County CCS programs use CMSNet to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. Through their respective MOUs, the MCPs and county CCS programs will develop protocols for the exchange of ICT data, as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of the CCS member and allow for COC of already approved service authorization requests, as required by this APL and applicable state and federal laws.

When a CCS-eligible member moves from a WCM county to a non-WCM county, the county CCS program and MCP, through their respective MOUs, will exchange ICT data. County CCS programs will continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS eligible member moves out of a WCM county, the county CCS program will notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data

[8] See WIC Section 14094.7(d)(4)(C), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.7.

for members to the county CCS program office. The county CCS program will then coordinate the sharing of CCS-eligible member data to the new county of residence. Similarly, when a member moves into a WCM county, the county CCS program will provide transfer data to the MCP as applicable.

D. Dispute Resolution and Provider Grievances

Disagreements between the MCP and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS.[9] The county CCS program shall communicate all resolved disputes in writing to the MCP within a timely manner. Disputes between the MCP and the county CCS program that are unable to be resolved will be referred by either entity to DHCS, via email to CCSWCM@dhcs.ca.gov, for review and final determination.[10]

MCPs must have a formal process to accept, acknowledge, and resolve provider disputes and grievances.[11] A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the MCP directly to the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

II. MCP RESPONSIBILITIES TO CCS-ELIGIBLE MEMBERS

A. Risk Level and Needs Assessment Process

The MCP will assess each CCS child's or youth's risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data, or by other means. MCPs are required to develop and complete the risk assessment process for WCM transition members, newly CCS-eligible members, or new CCS members enrolling in the MCP. The risk assessment process must include the development of a pediatric risk stratification process (PRSP) and an Individual Care Plan (ICP) for high risk members. All requirements are dependent on the member's risk level that is determined through the PRSP. Furthermore, nothing in this APL shall remove or limit existing survey or assessment requirements that the MCPs are responsible for outside WCM.

---

[9] See WIC Section 14093.06(b), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14093.06.
[10] Unresolved disputes must be referred to: CCSWCM@dhcs.ca.gov
[11] See WIC Section 14094.15(d), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.15.

1. **Pediatric Risk Stratification Process**
   MCPs must develop a pediatric risk stratification mechanism, or algorithm, to assess the CCS-eligible member's risk level that will be used to classify members into high and low risk categories, allowing the MCP to identify members who have more complex health care needs.

   MCPs are required to complete a risk stratification within 45 days of enrollment for all members including new members, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level by:

   - Review of medical utilization and claims processing data, including data received from the county and DHCS;
   - Utilization of existing member assessment or survey data; and
   - Telephonic or in-person communications, if available at time of PRSP.

   Members that do not have any medical utilization data, claims processing data history, or other assessments and/or survey information available will automatically be categorized as high risk until further assessment data is gathered to make an additional risk determination. The PRSP must be submitted to DHCS for review and approval.

2. **Risk Assessment and Individual Care Plan Process**
   MCPs must develop a process to assess a member's current health, including the CCS condition, to ensure that each CCS-eligible member receives case management, care coordination, provider referral, and/or service authorization from a CCS paneled provider; this will be dependent upon the member's designation as high or low risk.

   New Members and Newly CCS-eligible Members Determined High Risk
   Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of the member's ICP. Any risk assessment survey created by the MCP for the purposes of WCM is subject to review and approval by DHCS.

   Risk Assessment
   The risk assessment process must address:

   a) General Health Status and Recent Health Care Utilization. This may include, but is not limited to, caretaker self-report of child's health;

outpatient, emergency room, or inpatient visits; and school days missed due to illness, over a specified duration of time.

b) Health History. This includes both CCS and non-CCS diagnoses and past surgeries.

c) Specialty Provider Referral Needs.

d) Prescription Medication Utilization.

e) Specialized or Customized Durable Medical Equipment (DME) Needs (if applicable).

f) Need for Specialized Therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies (PT/OT /ST), mental or behavioral health services, and educational or developmental services.

g) Limitations of Activities of Daily Living or Daily Functioning (if applicable).

h) Demographics and Social History. This may include, but is not limited to, member demographics, assessment of home and school environments, and cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to assess the need for or impact of future health care services. These may include, but are not limited to, questions related to childhood developmental milestones; pediatric depression, anxiety or attention deficit screening; adolescent substance use; or adolescent sexual behaviors.

Individual Care Plan
MCPs are required to establish an ICP for all members determined high risk based on the results of the risk assessment process, with particular focus on specialty care, within 90 days of a completed risk assessment survey or other assessment by telephonic and/or in-person communication.[12] The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);
- County substance use disorder (SUD) or Drug Medi-Cal services;

[12] See WIC Section 14094.11(b)(4), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

The ICP will be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or their designated caregiver. The ICP should indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP should also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

a) Access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an interdisciplinary team is, and what the community resources are.

b) A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions.

c) Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams.

d) Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

Further, the MCP must reassess the member's risk level and needs annually at their CCS eligibility redetermination or upon significant change to the member's condition.

[13] See WIC Section 14094.11(c), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

New Members and Newly CCS-eligible Members Determined Low Risk
For new members and newly CCS-eligible members identified as lower risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of their enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

The MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination or upon significant change to the member's condition.

WCM Transitioning Members
For WCM transition members, the MCP must complete the PRSP within 45 days of transition, to determine each member's risk level, and complete all required telephonic and/or in-person communication and ICPs for high risk members and all required telephonic and/or in-person communication for low risk members within one year. Additionally, the MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination, or upon significant change to the member's condition.

MCPs must submit to DHCS for review and approval a phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year for WCM transition members.

Regardless of the risk level of a member, all communications, whether by phone or mail, must inform the member and/or his or her designated caregiver that the assessment will be provided in a linguistically and culturally appropriate manner and identify the method by which the provider will arrange for an in-person assessment.[14]

MCPs must refer all members, including new members, newly CCS-eligible members and WCM transition members who may have developed a new CCS-eligible condition, immediately to the county for CCS eligibility determination and not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination
MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs must ensure that information, education and support is continuously provided to the CCS-eligible member and their family to

[14] See APL 99-005, which is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL1999/MMCDAPL99005.pdf

assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:[15]

- Primary and preventive care services with specialty care services
- Medical therapy units (MTU)
- EPSDT[16]
- Regional center services
- Home and community-based services

1. **High Risk Infant Follow-Up Program**
   High Risk Infant Follow-Up (HRIF) is a program that helps identify infants who might develop CCS-eligible conditions after they are discharged from a Neonatal Intensive Care Unit (NICU). The MCP is responsible for coordinating and authorizing HRIF services for members and ensuring HRIF case management services. MCPs must notify the counties in writing, within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide COC information to the members.

2. **Age-Out Planning Responsibility**
   MCPs must establish and maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the members' CCS qualifying condition(s).

   MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[17]

3. **Pediatric Provider Phase-Out Plan**
   A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment to the child or youth. The MCPs must provide care coordination to

[15] See WIC Section14094.11(b)(1)-(6), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.11.
[16] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See APL 18-007, which is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-007.pdf
[17] See WIC Section 14094.12(j), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.12.

CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the service of a pediatric provider. The timing of the transition should be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

C. Continuity of Care

MCPs must establish and maintain a process to allow for members to receive COC with existing CCS provider(s) for up to 12 months, in accordance with WIC Section 14094.13.[18] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all other applicable APLs regarding COC. The sections below include additional COC requirements that only pertain to the WCM program.

1. Specialized or Customized Durable Medical Equipment

If the MCP member has an established relationship with a specialized or customized durable medical equipment (DME) provider, MCPs must provide access to that provider for up to 12 months.[19] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service rates, unless the DME provider and the MCP enter into an agreement on an alternative payment methodology that is mutually agreed upon. The MCP may extend the COC period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[20]

Specialized or Customized DME must meet all of the following criteria:

- Is uniquely constructed or substantially modified solely for the use of the member.
- Is made to order or adapted to meet the specific needs of the member.
- Is uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

2. COC Case Management[21]

MCPs must ensure CCS-eligible members receive expert case management,

[18] See WIC Section 14094.13, which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.13.
[19] See WIC Section 14094.12(f), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.12.&lawCode=WIC
[20] See WIC Section 14094.13(b)(3) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[21] See WIC Section 14094.13(e), (f) and (g), which are available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing the CCS-eligible member, member's family, or designated caregiver to request COC case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with a MCP case manager who has received adequate training on the county CCS Program and who has clinical experience with the CCS population or pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services The MCP must send a follow-up notice 30 days prior to the start of the transition.

3. **Authorized Prescription Drugs**
   CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed prescription drug that is part of their prescribed therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.[22]

4. **Appealing COC Limitations**
   MCPs must provide CCS-eligible members with information regarding the WCM appeal process for COC limitations, in writing, 60 days prior to the end of their authorized COC period. The notice must explain the member's right to petition the MCP for an extension of the COC period, the criteria used to evaluate the petition, and the appeals process if the MCP denies the petition.[23] The appeals process notice must include the following information:

   - The CCS-eligible member must first appeal a COC decision with the MCP.
   - A CCS-eligible member, member's family or designated caregiver of the CCS-eligible member may appeal the COC limitation to the DHCS director or his or her designee after exhausting the MCP's appeal process.

[22] See WIC Section 14094.13(d)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[23] See WIC Section 14094.13(k), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

- The DHCS director or designee will have five (5) days from the date of appeal to inform the family or caregiver of receipt of the request and must provide a decision on the appeal within 30 calendar days from the date of the request. If the member's health is at risk, the DHCS director or designee will inform the member of the decision within 72 hours.[24]

In addition to the protections set forth above, MCP members also have COC rights under current state law.

D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals and state fair hearing processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal and state fair hearing rights as provided under state and federal law.[25] MCPs must provide timely processes for accepting and acting upon member complaints and grievances. Members appealing a CCS eligibility determination must appeal to the county CCS program.

E. Transportation

MCPs must provide the CCS Maintenance and Transportation (M&T) benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary costs (i.e. parking, tolls, etc.), in addition to transportation expenses, and must comply with all requirements listed in N.L. 03-0810.[26] These services include, but are not limited to, M&T for out of county and out of state services.

MCPs must also comply with all requirements listed in APL 17-010[27] for CCS-eligible members to obtain non-emergency medical transportation (NEMT) and non-medical transportation (NMT) for all other services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.

[24] See APL 17-006, which is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf
[25] See APL 17-006
[26] See CCS N.L. 03-0810, which is available at: http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl030810.pdf
[27] APL 17-010 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-010.pdf

F. Out-of-Network Access

MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the MCP's provider network or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services.

G. Advisory Committees

MCPs must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers.[28] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[29] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also establish a quarterly Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.[30]

III. WCM Payment Structure

A. Payment and Fee Rate

MCPs are required to pay providers at rates that are at least equal to the applicable CCS fee-for-service rates, unless the provider and the MCP enter into

[28] See WIC Section 14094.7(d)(3), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.7.&lawCode=WIC
[29] See WIC Section 14094.17(b)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC
[30] See WIC Section 14094.17(a), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC

an agreement on an alternative payment methodology that is mutually agreed upon.[31]

The payor for NICU services is as follows: an MCP shall pay for NICU services in counties where NICU is carved into the MCP's rate, and DHCS shall pay in counties where NICU is carved out of the MCP's rate.[32]

For WCM counties, all NICU authorizations will be sent to the MCP in which the child is enrolled. The MCP will review authorizations and determine whether or not the services meet CCS NICU requirements. However, claims may be processed and paid by either DHCS or the MCP.

In counties where CCS NICU is carved into the MCP's rate, the MCP will pay all NICU and CCS NICU claims. For counties where CCS is currently carved-out, the MCP will process and pay non-CCS NICU claims, and the State's Fiscal Intermediary will pay CCS NICU claims. Payments made by State's Fiscal Intermediary will be based on the MCP's approval of meeting CCS NICU requirements.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities for WCM:

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-In Counties: Marin, Merced, Monterey, Napa, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, and Yolo	MCP	MCP	MCP

[31] See WIC Section 14094.16(b), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.16.
[32] See the Division of Responsibility chart

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-Out: Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Orange, Shasta, Siskiyou, Sonoma, and Trinity	MCP	MCP	DHCS

IV. MCP Responsibilities to DHCS

A. Network Certification

MCPs are required to have an adequate network of providers to serve the CCS-eligible population including physicians, specialists, allied professionals, Special Care Centers, hospitals, home health agencies, and specialized and customizable DME providers. Each network of providers will be reviewed by DHCS and certified annually.

The certification requires the MCP and their delegated entities to submit updated policies and procedures and an updated provider network template to ensure the MCP's network of providers meets network adequacy requirements as described in the Network Certification APL Attachments.[33]

MCPs must demonstrate that the provider network contains an adequate provider overlap with CCS-paneled providers. MCPs must submit provider network documentation to DHCS, as described in APL 18-005. Members cannot be limited to a single delegated entity's provider network. The MCP must ensure members have access to all medically necessary CCS-paneled providers within the MCP's entire provider network. MCPs must submit policies and procedures to DHCS no later than 105 days before the start of the contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional

[33] APL 18-005 and its attachments are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

approval status.[34] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[35] The MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[36]

MCPs are required to verify the credentials of all contracted CCS-paneled providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. The MCP's written policies and procedures must follow the credentialing and recredentialing guidelines of APL 17-019.[37] MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[38]

- Procedures for pre-authorization, concurrent review, and retrospective review.
- A list of services requiring prior authorization and the utilization review criteria.
- Procedures for the utilization review appeals process for providers and members.
- Procedures that specify timeframes for medical authorization.
- Procedures to detect both under- and over-utilization of health care services.

In addition to the UM processes above, MCPs are responsible for conducting NICU acuity assessments and authorizations in all WCM counties.[39]

---

[34] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[35] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[36] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf
[37] APL 17-019 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-019.pdf
[38] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[39] See WIC 14094.65, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.65.&lawCode=WIC

D. MCP Reporting Requirements

1. Quality Performance Measures

DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a form and manner specified by DHCS.

2. Reporting and Monitoring

DHCS will develop specific monitoring and oversight standards for MCPs. MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companions guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required data in a form and manner specified by DHCS and must comply with all contractual requirements.

E. Delegation of Authority

In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in APL 17-004.[40] If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[40] APL 17-004 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-004.pdf

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Modifications and Development of CalOptima Policies and Procedures Related to Whole-Child Model and Annual Policy Review

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Tracy Hitzeman, Executive Director, Clinical Operations, (714) 246-8400
Sesha Mudunuri, Executive Director, Operations, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to modify existing and develop new Policies and Procedures in connection with Whole Child Model initiative as follows:

1. FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group [Medi-Cal]
2. GG.1101: California Children's Services [Medi-Cal]
3. GG.1112: Standing Referral to Specialist Provider or Specialty Care Center [Medi-Cal, OneCare, OneCare Connect]
4. GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transfer into CalOptima [Medi-Cal]
5. GG.1330: Case Management – California Children's Services Program/Whole Child Model [Medi-Cal]
6. GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair [Medi-Cal, OneCare, OneCare Connect]
7. GG.1535: Utilization Review Criteria and Guidelines [Medi-Cal, OneCare, OneCare Connect]
8. GG. 1547: Maintenance and Transportation [Medi-Cal]

Background/Discussion

Periodically, CalOptima establishes new or modifies existing Policies and Procedures to implement new or modified, laws, regulatory guidance, contracts and business practices. CalOptima has established an annual policy review process by which Policies and Procedures are updated and subject to peer review. New and modified Policy and Procedures are developed on an ad hoc basis as new laws, regulations, guidelines, or programs are established. Most recently, the following have impacted CalOptima's Policies and Procedures:

Whole-Child Model

CalOptima expects to integrate California Children's Services (CCS) into its Medi-Cal managed care plan through the Whole-Child Model (WCM) effective January 1, 2019. On June 7, 2018, the CalOptima Board of Directors authorized execution of an Amendment to the Primary Agreement between DHCS and CalOptima with respect to implementation of the WCM program. On September 6, 2018, the CalOptima Board of Directors authorized the Chief Executive Officer to modify existing and develop new Policies and Procedures in connection with WCM. Principle guidance is outlined in Senate Bill 586, signed by Governor Brown on September 25, 2016, and the DHCS's All Plan Letter

Back to Agenda

(APL) 18-011 released on June 28, 2018. In addition, DHCS has provided additional reporting requirements and implementation deliverables.

Below is additional information regarding the new and modified policies:

1. ***FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group*** outlines CalOptima's payment methodologies for a provider or practitioner that provides covered services to a member of CalOptima Direct or a member enrolled in a shared risk group. For those members enrolled in a shared risk group, this policy shall only apply to covered services for which CalOptima is financially responsible, in accordance with the Division of Financial Responsibility (DOFR). CalOptima revised policy pursuant to the CalOptima annual review process to incorporate relevant language pertaining to the American Indian Health Service Program and ensure compliance with the Department of Health Care Services (DHCS), All Plan Letter (APL) 17-020: American Indian Health Programs, including APL attachment 1 (revised 08/07/18) and attachment 2 (revised 01/12/18).

2. ***GG.1101: California Children's Services***, which includes attachment A, defines the guidelines for coordination of care between CalOptima or a health network and the local California Children's Services (CCS) program for members eligible with the California Children's Services (CCS) program and transitioned into the Whole Child Model (WCM) program, newly CCS-eligible members, or new CCS members enrolling in CalOptima, including the identification and referral of members with CCS-eligible conditions. CalOptima revised policy pursuant to the CalOptima annual review process to ensure compliance with the Department of Health Care Services (DHCS), All Plan Letter (APL) 18-011: California Children's Services Whole Child Model. Policy outlines CalOptima's responsibility for authorizations, claims and case management beginning January 1, 2019.

3. ***GG.1112: Standing Referral to Specialist Provider or Specialty Care Center*** defines the conditions under which CalOptima and its health networks shall authorize a standing referral to a specialty care provider or a specialty care center. CalOptima revised policy pursuant to the CalOptima annual review process to incorporate standing referrals for members with California Children's Services (CCS)-eligible conditions under the Whole Child Model (WCM) effective 01/01/19 and update references to include CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

4. ***GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transfer into CalOptima*** establishes the continuity of care guidelines and the process to identify members who have expedited care needs for newly enrolled Medi-Cal members who transition into CalOptima or existing members whose covered services are transitioned from Medi-Cal Fee-for-Service (FFS) to CalOptima. CalOptima revised policy pursuant to the CalOptima annual review process to ensure compliance with the Department of Health Care Services (DHCS), All Plan Letter (APL) 18-008 *(revised)*: Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed Care *(supersedes APL 15-019)* and APL 18-011 California Children's Services Whole Child Model Program.

Back to Agenda

5. ***GG.1330: Case Management – California Children's Services Program/Whole Child Model*** defines the guidelines for the provision of case management by CalOptima or a health network to CalOptima members eligible with the California Children's Services (CCS) program and transitioned into the Whole Child Model (WCM) program, newly CCS-eligible members or new CCS members enrolling in CalOptima. CalOptima developed this policy to ensure compliance with the Department of Health Care Services (DHCS), All Plan Letter (APL) 18-011: California Children's Service Whole Child Model Program, as well as the Welfare and Institutions Code §§ 14094.7(d)(4)(C), 14094.11(b)(1)-(6), 14094.11(c), 14094.12(j), 14094.13(e)-(g).

6. ***GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair*** defines the criteria and process for coverage of a wheelchair, seating and positioning components (SPC), and accessories for a member. CalOptima revised policy pursuant to the CalOptima annual review process to align policy with current operational processes, clarify that a health network will provide continuity of care for CCS eligible members transitioning into the Whole Child Model (WCM) program with a specialized or customized durable medical equipment provider, and ensure compliance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program.

7. ***GG.1535: Utilization Review Criteria and Guidelines*** describes the process by which CalOptima establishes utilization criteria and guidelines to ensure that decisions related to utilization management and coverage or denial of organization determinations are made in a consistent manner and comport with program requirements and local and national care standards. CalOptima revised policy pursuant to the CalOptima review process to align policy with current operational processes and ensure compliance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program.

8. ***GG. 1547: Maintenance and Transportation*** defines the criteria and process for administration of the maintenance and transportation benefit for CalOptima members eligible with the California Children's Services (CCS) program. CalOptima revised policy pursuant to the CalOptima review process to align policy with current operational processes and ensure compliance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program.

Fiscal Impact

The recommended action to modify existing and develop new policies and procedures related to the WCM program and the annual policy review is a budgeted item, with no anticipated additional fiscal impact. Management has included projected medical and administrative expenses associated with the WCM program and the annual policy review in the CalOptima Fiscal Year 2018-19 Operating Budget approved by the Board on June 7, 2018. Staff expects the budgeted expenses will be sufficient to cover the costs resulting from the revised or new policies and procedures.

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 versions.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group [Medi-Cal]
2. GG.1101: California Children's Services [Medi-Cal]
3. GG.1112: Standing Referral to Specialist Provider or Specialty Care Center [Medi-Cal, OneCare, OneCare Connect]
4. GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transfer into CalOptima [Medi-Cal]
5. GG.1330PP: Case Management – California Children's Services Program/Whole Child Model [Medi-Cal]
6. GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair [Medi-Cal, OneCare, OneCare Connect]
7. GG.1535: Utilization Review Criteria and Guidelines [Medi-Cal, OneCare, OneCare Connect]
8. GG. 1547PP: Maintenance and Transportation [Medi-Cal]
9. DHCS All Plan Letter 17-020: 17-020: American Indian Health Programs, including attachment 1 *(revised 08/07/18)* and attachment 2 *(revised 01/12/18)*.
10. DHCS All Plan Letter APL 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care
11. DHCS All Plan Letter 18-011 California Children's Services Whole Child Model Program

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

Back to Agenda

Policy #:	FF.1003
Title:	**Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/07
Last Review Date:	10/04/18~~06/01/17~~
Last Revised Date:	10/04/18~~06/01/17~~

I. PURPOSE

This policy outlines CalOptima's payment methodologies for a Provider or Practitioner that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group. For those Members enrolled in a Shared Risk Group, this policy shall only apply to Covered Services for which CalOptima is financially responsible, in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. Hospital Payment: Subject to all applicable Claims policies and Utilization Management (UM) policies, CalOptima shall reimburse a hospital that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, as follows:

1. Contracted Hospital: CalOptima's reimbursement to a CalOptima Contracted Hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CCN or a Member Enrolled in a Shared Risk Group.

2. Non-Contracted Hospital: CalOptima's reimbursement to a Non-Contracted Hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, that has received appropriate authorization, unless exempt from such authorization, shall be in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's prior authorization policies, shall be based on the following:

   a. Outpatient Emergency and Non-Emergency Services: CalOptima shall reimburse non-contracted outpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at the same amount paid by the California Department of Health Care Services (DHCS) for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal Fee-for-Service (FFS) program, in accordance with Section 14091.3(c)(1) of the California Welfare and Institutions Code and Section 1932(b)(2)(D) of the Social Security Act.

   b. Emergency Inpatient Services: For dates of service on or after July 1, 2013, CalOptima shall reimburse non-contracted emergency inpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group using the All

Patient Refined Diagnosis Related Groups (APR-DRG) rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

c. Non-emergency Inpatient Services: In the absence of any negotiated rate agreed to, in writing, between CalOptima and a hospital, CalOptima shall reimburse a hospital using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code. Prior authorization is required for non-emergency inpatient services.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

d. Out of State Hospitals: For dates of service on or after July 1, 2013, CalOptima shall reimburse a hospital located outside of California using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

e. Border Hospitals: For dates of service after July 1, 2015, CalOptima shall apply the State Plan Amendment (SPA) 15-020 changes established in the Medi-Cal FFS system to the DRG-based rates paid to out-of-network Border Hospitals for acute care hospital inpatient emergency and post-stabilization services, with respect to admissions occurring on or after July 1, 2015. CalOptima may pay a lower negotiated rate agreed to by the hospital.

3. Non-Emergency Non-Authorized Services: CalOptima shall not reimburse a hospital for any services that are subject to authorization requirements, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's authorization policies, for which such authorization has not been secured.

B. Practitioner Payment: For purposes of this policy a Practitioner does not include those Providers who render services to Members that are not a benefit included in Covered Services provided by the CalOptima Medi-Cal program. Subject to all applicable CalOptima Claims and Utilization Management (UM) policies, CalOptima shall reimburse a Practitioner providing Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, as follows:

1. Contracted Practitioner: CalOptima shall reimburse a Contracted Practitioner based on the terms and conditions of the contract between such Contracted Practitioner and CalOptima.

2. Non-Contracted Practitioner: CalOptima's reimbursement to a Non-Contracted Practitioner for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on the following:

a. Emergency Services: CalOptima shall reimburse a Non-Contracted Practitioner that provides Emergency Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

b. Non-Emergency Services: CalOptima shall reimburse a Non-Contracted Practitioner for Covered Services rendered to a Member of CalOptima Direct, or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible on a fee-for-service basis as follows:

i. For dates of service on or after January 1, 2011, CalOptima shall reimburse professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program. .

ii. Except as otherwise provided in this subsection, CalOptima shall reimburse a physician who is a California Children's Service (CCS) Program -paneled Provider, and who is recognized as a specialist physician by CCS, at one hundred forty percent (140%) of the CalOptima Medi-Cal Fee Schedule for Covered Services rendered to a Member who is less than twenty-one (21) years of age.

iii. CalOptima shall reimburse technical component of pathology, clinical laboratory, and radiology services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

iv. CalOptima shall reimburse Child Health and Disability Prevention (CHDP) services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

v. CalOptima shall reimburse injectables at one hundred percent 100% of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

vi. For dates of service on or after January 1, 2011, CalOptima shall reimburse Surgical and Incontinence Supplies at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

vii. CalOptima shall reimburse "By Report" procedure codes in the same manner as DHCS.

viii. CalOptima shall reimburse Family Planning Services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

a) CalOptima shall reimburse up thirteen cycles of oral contraceptives, a twelve (12) month supply of patches (36 patches), and a twelve (12) month supply of vaginal rings (12 rings), if such quantity is dispensed in an onsite clinic and billed by a Qualified Family Planning Provider, including a non-contracted Qualified Family Planning Provider, or dispensed by a pharmacist with a protocol approved by the California State Board of Pharmacy and the Medical Board of California.

C. If a non-contracted birthing center is used for non-contracted Certified Nurse Midwife or Certified Nurse Practitioner services, CalOptima shall reimburse facility and professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

D. Federally Qualified Health Center (FQHC) Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an FQHC that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible, as follows:

1. Contracted FQHC: CalOptima shall reimburse a Contracted FQHC based on the terms and conditions of the contract between such FQHC and CalOptima. CalOptima's contracted rates for an FQHC shall not be less than CalOptima's contracted rates to any other Provider or Practitioner for the same scope of services.

2. Non-contracted FQHC:

   a. CalOptima shall reimburse a non-contracted FQHC for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

   b. CalOptima shall reimburse a non-contracted FQHC for CHDP services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

   c. CalOptima shall reimburse a non-contracted FQHC based on the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) for each procedure rendered, and not the FQHC's all-inclusive rate.

E. American Indian Health Service ~~Facility~~ Program Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Indian Health Service Facility that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible as follows:

1. Contracted American Indian Health Service ~~Facility~~Program:

   a. If the American Indian Health Service ~~Facility~~Program is a rural health clinic or qualifies as an FQHC, CalOptima shall reimburse the ~~facility~~program at the ~~facility's~~program's interim per visit rate as established by DHCS, or through an alternate reimbursement methodology approved in writing by DHCS.

   b. If the American Indian Health Service ~~Facility~~Program is a rural health clinic or FQHC, and CalOptima and the ~~facility~~program have agreed to an at-risk rate and the ~~facility~~program has waived its rights to cost-based reimbursement under its contract with CalOptima, CalOptima shall reimburse the ~~facility~~program at the negotiated rate.

   c. If the American Indian Health Service ~~Facility~~Program is entitled to be reimbursed as an American Indian Health Service Provider by the federal government at a rate other than the rate described in (a) above, CalOptima shall reimburse the ~~facility~~program at the American Indian Health Service payment rate.

2. Non-contracted American Indian Health Service ~~Facility~~Program: CalOptima shall reimburse a non-contracted American Indian Health Service ~~Facility~~Program at the approved Medi-Cal per visit rate for that facility.

3. Effective for dates of service on or after January 1, 2018, CalOptima shall reimburse contracted and non-contracted American Indian Health Service Programs at the current and applicable Office of Management and Budget (OMB) encounter rate, published in the Federal Register . These rates shall apply when services are provided to Members who are qualified to receive services from an American Indian Health Services Program, as set forth in Supplement 6, Attachment 4.19-B of the California Medicaid State Plan.

4. CalOptima shall ensure that the following criteria are met for receipt of payments:

   a. The American Indian Health Program provider must be identified by DHCS;

   b. Service must be a Covered Service included in CalOptima's contract with DHCS;

   c. As set forth in California Medicaid State Plan Supplemental 6. Attachment 4.19-B, only one rate payment per day, per category, shall be allowed within the following three (3) categories. This allows for a maximum of three (3) payments per day, one (1) from each category:

      i. Medical health visit;

      ii. Mental health visit;

      ~~i.~~iii. Ambulatory visit.

F. Ancillary Service Provider Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Ancillary Service Provider for Covered Services rendered to a Member of

CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible as follows:

1. CalOptima shall reimburse a contracted Ancillary Services Provider based on the terms and conditions of the contract between such Contracted Ancillary Service Provider and CalOptima.

2. CalOptima shall reimburse a Non-Contracted Ancillary Services Provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

G. Non-Contracted Hospitals, Non-Contracted Practitioners, and Non-Contracted Ancillary Service Providers shall not be eligible to participate in any CalOptima incentive payment programs.

H. A Practitioner or Provider shall not bill a Member for any portion of a Covered Service, as set forth in Title 22 of the California Code of Regulations, Section 51002.

I. CalOptima shall recover, or reimburse, overpayments in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

III. PROCEDURE

A. A Provider or Practitioner that renders Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible shall submit claims to CalOptima, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1000: Glossary of Terms
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
E. CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group
F. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
G. CalOptima Policy GG.1116: Pediatric Preventive Services
H. CalOptima Policy HH.~~2022~~2022Δ: Record Retention and Access

I. CalOptima Policy HH.~~5000~~5000Δ: Provider Overpayment Investigation and Determination
J. Title 22 of the California Code of Regulations, §§51002, 55000 and 55140(a)
K. Section 1932(b)(2)(D) of the Social Security Act
L. California Welfare and Institutions Code,§§, 14105.28 and 14166.245
M. California Health and Safety Code, §1797.1
N. This policy supersedes:
   a. CalOptima Financial Letter dated August 25, 1995: Fee-for-service rates
   b. CalOptima Financial Bulletin #3: Inpatient hospital reimbursement rates under "CalOptima Direct"
   c. CalOptima Financial Bulletin #5: Revised "CalOptima Direct" inpatient hospital rates
   d. CalOptima Financial Bulletin #10: Family planning services
   e. CalOptima Financial Bulletin #17: Additions to CalOptima Direct inpatient hospital rates
   f. CalOptima Financial Bulletin #19: CalOptima Direct rates effective October 1, 1999
   g. CalOptima Financial Bulletin #24: CalOptima Direct rates effective July 1, 2002
   h. CalOptima Financial Bulletin #29: CalOptima Direct rates effective March 1, 2004
O. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
~~P.~~Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-008: Reimbursement for Non-Contracted Hospital Emergency Inpatient Services
~~Q.~~R. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-010: Hospital Payment for Medi-Cal Post-Stabilization Services
~~R.~~S. Department of Health Care Services (DHCS) Policy Letter (PL) 96-09: Sexually Transmitted Disease Services in Medi-Cal Managed Care
~~S.~~T. Department of Health Care Services (DHCS) Policy Letter (PL) 13-004: Rates For Emergency and Post-Stabilization Acute Inpatient Services Provided By Out-Of-Network General Acute Care Hospitals Based On Diagnosis Related Groups Effective July 1, 2013
~~T.~~U. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-003(*revised*): Family Planning Services Policy for Contraceptive Supplies
~~U.~~V. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-017: Provision of Certified Nurse Midwife and Alternative Birth Center Facility Services (Revised)
~~V.~~W. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-016: Rate Changes for Emergency and Post-Stabilization Services Provided by Out-of-Network "Border" Hospitals Under the Diagnostic Related Group Payment Methodology

VI. REGULATORY AGENCY APPROVALS

A. 11/09/17: Department of Health Care Services
B. 07/06/16: Department of Health Care Services
C. 03/10/14: Department of Health Care Services
D. 12/10/09: Department of Health Care Services

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 06/06/13: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 11/05/09: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 11/06/08: Regular Meeting of the CalOptima Board of Directors
~~D.~~E. 10/02/08: Regular Meeting of the CalOptima Board of Directors
~~E.~~F. 06/03/08: Regular Meeting of the CalOptima Board of Directors
~~F.~~G. 12/04/07: Regular Meeting of the CalOptima Board of Directors
~~G.~~H. 06/05/07: Regular Meeting of the CalOptima Board of Directors
~~H.~~I. 06/04/02: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2007	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2009	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2011	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	06/01/2013	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	03/01/2015	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	04/01/2016	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	06/01/2017	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	10/04/2018	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group	Medi-Cal

IX. GLOSSARY

Term	Definition
Border Hospital	Those hospitals located outside the State of California that are within 55 miles' driving distance from the nearest physical at which a road crosses the California border as defined by the U.S. Geological Survey.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations, Sections 41515.2 through 41518.9.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
Certified Nurse Midwife	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code with additional training as a midwife who is certified to deliver infants and provide prenatal and postpartum care, newborn care, and some routine care of woman.
Certified Nurse Practitioner	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program conforms to board standards as specified in Title 16 California Code of Regulations, Section 1484.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, California Code of Regulations (CCR), Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, 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.

Term	Definition
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and IUCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
Federally Qualified Health Center	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
American Indian Health Services ~~Facility~~Program	~~Facilities~~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.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	For purposes of this policy, a person or institution that furnishes Covered Services to Members.

Term	Definition
Qualified Family Planning Provider	A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to an enrollee as specified in Title 22, California Code of Regulations, Section 51200. A Physician, Physician Assistant (under the supervision of a Physician), Certified Nurse Midwife, and Nurse Practitioner are authorized to dispense medications. Pursuant to California Business and Professions Code section 2725.2, if these contraceptives are dispensed by a Registered Nurse (RN), the RN must have completed required training pursuant to Business and Professions Code section 2725.2 and the contraceptives must be billed with Evaluation and Management (E&M) procedure codes 99201, 99211, or 99212 with modifier TD (TD modifier as used for RN for (Behavioral Health) as found in the Medi-Cal Provider Manual.
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

Policy #:	FF.1003
Title:	**Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/07
Last Review Date:	10/04/18
Last Revised Date:	10/04/18

I. PURPOSE

This policy outlines CalOptima's payment methodologies for a Provider or Practitioner that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group. For those Members enrolled in a Shared Risk Group, this policy shall only apply to Covered Services for which CalOptima is financially responsible, in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. Hospital Payment: Subject to all applicable Claims policies and Utilization Management (UM) policies, CalOptima shall reimburse a hospital that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, as follows:

1. Contracted Hospital: CalOptima's reimbursement to a CalOptima Contracted Hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CCN or a Member Enrolled in a Shared Risk Group.

2. Non-Contracted Hospital: CalOptima's reimbursement to a Non-Contracted Hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, that has received appropriate authorization, unless exempt from such authorization, shall be in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's prior authorization policies, shall be based on the following:

   a. Outpatient Emergency and Non-Emergency Services: CalOptima shall reimburse non-contracted outpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at the same amount paid by the California Department of Health Care Services (DHCS) for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal Fee-for-Service (FFS) program, in accordance with Section 14091.3(c)(1) of the California Welfare and Institutions Code and Section 1932(b)(2)(D) of the Social Security Act.

   b. Emergency Inpatient Services: For dates of service on or after July 1, 2013, CalOptima shall reimburse non-contracted emergency inpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group using the All

Patient Refined Diagnosis Related Groups (APR-DRG) rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

c. Non-emergency Inpatient Services: In the absence of any negotiated rate agreed to, in writing, between CalOptima and a hospital, CalOptima shall reimburse a hospital using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code. Prior authorization is required for non-emergency inpatient services.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

d. Out of State Hospitals: For dates of service on or after July 1, 2013, CalOptima shall reimburse a hospital located outside of California using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

e. Border Hospitals: For dates of service after July 1, 2015, CalOptima shall apply the State Plan Amendment (SPA) 15-020 changes established in the Medi-Cal FFS system to the DRG-based rates paid to out-of-network Border Hospitals for acute care hospital inpatient emergency and post-stabilization services, with respect to admissions occurring on or after July 1, 2015. CalOptima may pay a lower negotiated rate agreed to by the hospital.

3. Non-Emergency Non-Authorized Services: CalOptima shall not reimburse a hospital for any services that are subject to authorization requirements, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's authorization policies, for which such authorization has not been secured.

B. Practitioner Payment: For purposes of this policy a Practitioner does not include those Providers who render services to Members that are not a benefit included in Covered Services provided by the CalOptima Medi-Cal program. Subject to all applicable CalOptima Claims and Utilization Management (UM) policies, CalOptima shall reimburse a Practitioner providing Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, as follows:

1. Contracted Practitioner: CalOptima shall reimburse a Contracted Practitioner based on the terms and conditions of the contract between such Contracted Practitioner and CalOptima.

2. Non-Contracted Practitioner: CalOptima's reimbursement to a Non-Contracted Practitioner for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on the following:

a. Emergency Services: CalOptima shall reimburse a Non-Contracted Practitioner that provides Emergency Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

b. Non-Emergency Services: CalOptima shall reimburse a Non-Contracted Practitioner for Covered Services rendered to a Member of CalOptima Direct, or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible on a fee-for-service basis as follows:

i. For dates of service on or after January 1, 2011, CalOptima shall reimburse professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program. .

ii. Except as otherwise provided in this subsection, CalOptima shall reimburse a physician who is a California Children's Service (CCS) Program -paneled Provider, and who is recognized as a specialist physician by CCS, at one hundred forty percent (140%) of the CalOptima Medi-Cal Fee Schedule for Covered Services rendered to a Member who is less than twenty-one (21) years of age.

iii. CalOptima shall reimburse technical component of pathology, clinical laboratory, and radiology services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

iv. CalOptima shall reimburse Child Health and Disability Prevention (CHDP) services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

v. CalOptima shall reimburse injectables at one hundred percent 100% of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

vi. For dates of service on or after January 1, 2011, CalOptima shall reimburse Surgical and Incontinence Supplies at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

vii. CalOptima shall reimburse "By Report" procedure codes in the same manner as DHCS.

viii. CalOptima shall reimburse Family Planning Services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

a) CalOptima shall reimburse up thirteen cycles of oral contraceptives, a twelve (12) month supply of patches (36 patches), and a twelve (12) month supply of vaginal rings (12 rings), if such quantity is dispensed in an onsite clinic and billed by a Qualified Family Planning Provider, including a non-contracted Qualified Family Planning Provider, or dispensed by a pharmacist with a protocol approved by the California State Board of Pharmacy and the Medical Board of California.

C. If a non-contracted birthing center is used for non-contracted Certified Nurse Midwife or Certified Nurse Practitioner services, CalOptima shall reimburse facility and professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

D. Federally Qualified Health Center (FQHC) Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an FQHC that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible, as follows:

1. Contracted FQHC: CalOptima shall reimburse a Contracted FQHC based on the terms and conditions of the contract between such FQHC and CalOptima. CalOptima's contracted rates for an FQHC shall not be less than CalOptima's contracted rates to any other Provider or Practitioner for the same scope of services.

2. Non-contracted FQHC:

a. CalOptima shall reimburse a non-contracted FQHC for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

b. CalOptima shall reimburse a non-contracted FQHC for CHDP services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

c. CalOptima shall reimburse a non-contracted FQHC based on the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) for each procedure rendered, and not the FQHC's all-inclusive rate.

E. American Indian Health Service Program Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Indian Health Service Facility that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible as follows:

1. Contracted American Indian Health Service Program:

a. If the American Indian Health Service Program is a rural health clinic or qualifies as an FQHC, CalOptima shall reimburse the program at the program's interim per visit rate as established by DHCS, or through an alternate reimbursement methodology approved in writing by DHCS.

b. If the American Indian Health Service Program is a rural health clinic or FQHC, and CalOptima and the program have agreed to an at-risk rate and the program has waived its rights to cost-based reimbursement under its contract with CalOptima, CalOptima shall reimburse the program at the negotiated rate.

c. If the American Indian Health Service Program is entitled to be reimbursed as an American Indian Health Service Provider by the federal government at a rate other than the rate described in (a) above, CalOptima shall reimburse the program at the American Indian Health Service payment rate.

2. Non-contracted American Indian Health Service Program: CalOptima shall reimburse a non-contracted American Indian Health Service Program at the approved Medi-Cal per visit rate for that facility.

3. Effective for dates of service on or after January 1, 2018, CalOptima shall reimburse contracted and non-contracted American Indian Health Service Programs at the current and applicable Office of Management and Budget (OMB) encounter rate, published in the Federal Register . These rates shall apply when services are provided to Members who are qualified to receive services from an American Indian Health Services Program, as set forth in Supplement 6, Attachment 4.19-B of the California Medicaid State Plan.

4. CalOptima shall ensure that the following criteria are met for receipt of payments:

a. The American Indian Health Program provider must be identified by DHCS;

b. Service must be a Covered Service included in CalOptima's contract with DHCS;

c. As set forth in California Medicaid State Plan Supplemental 6. Attachment 4.19-B, only one rate payment per day, per category, shall be allowed within the following three (3) categories. This allows for a maximum of three (3) payments per day, one (1) from each category:

i. Medical health visit;

ii. Mental health visit;

iii. Ambulatory visit.

F. Ancillary Service Provider Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Ancillary Service Provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible as follows:

1. CalOptima shall reimburse a contracted Ancillary Services Provider based on the terms and conditions of the contract between such Contracted Ancillary Service Provider and CalOptima.

2. CalOptima shall reimburse a Non-Contracted Ancillary Services Provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

G. Non-Contracted Hospitals, Non-Contracted Practitioners, and Non-Contracted Ancillary Service Providers shall not be eligible to participate in any CalOptima incentive payment programs.

H. A Practitioner or Provider shall not bill a Member for any portion of a Covered Service, as set forth in Title 22 of the California Code of Regulations, Section 51002.

I. CalOptima shall recover, or reimburse, overpayments in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

III. PROCEDURE

A. A Provider or Practitioner that renders Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible shall submit claims to CalOptima, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1000: Glossary of Terms
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
E. CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group
F. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
G. CalOptima Policy GG.1116: Pediatric Preventive Services
H. CalOptima Policy HH.2022Δ: Record Retention and Access
I. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
J. Title 22 of the California Code of Regulations, §§51002, 55000 and 55140(a)
K. Section 1932(b)(2)(D) of the Social Security Act
L. California Welfare and Institutions Code,§§, 14105.28 and 14166.245

M. California Health and Safety Code, §1797.1
N. This policy supersedes:
   a. CalOptima Financial Letter dated August 25, 1995: Fee-for-service rates
   b. CalOptima Financial Bulletin #3: Inpatient hospital reimbursement rates under "CalOptima Direct"
   c. CalOptima Financial Bulletin #5: Revised "CalOptima Direct" inpatient hospital rates
   d. CalOptima Financial Bulletin #10: Family planning services
   e. CalOptima Financial Bulletin #17: Additions to CalOptima Direct inpatient hospital rates
   f. CalOptima Financial Bulletin #19: CalOptima Direct rates effective October 1, 1999
   g. CalOptima Financial Bulletin #24: CalOptima Direct rates effective July 1, 2002
   h. CalOptima Financial Bulletin #29: CalOptima Direct rates effective March 1, 2004
O. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-008: Reimbursement for Non-Contracted Hospital Emergency Inpatient Services
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-010: Hospital Payment for Medi-Cal Post-Stabilization Services
S. Department of Health Care Services (DHCS) Policy Letter (PL) 96-09: Sexually Transmitted Disease Services in Medi-Cal Managed Care
T. Department of Health Care Services (DHCS) Policy Letter (PL) 13-004: Rates For Emergency and Post-Stabilization Acute Inpatient Services Provided By Out-Of-Network General Acute Care Hospitals Based On Diagnosis Related Groups Effective July 1, 2013
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-003(*revised*): Family Planning Services Policy for Contraceptive Supplies
V. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-017: Provision of Certified Nurse Midwife and Alternative Birth Center Facility Services (Revised)
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-016: Rate Changes for Emergency and Post-Stabilization Services Provided by Out-of-Network "Border" Hospitals Under the Diagnostic Related Group Payment Methodology

VI. REGULATORY AGENCY APPROVALS

A. 11/09/17: Department of Health Care Services
B. 07/06/16: Department of Health Care Services
C. 03/10/14: Department of Health Care Services
D. 12/10/09: Department of Health Care Services

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors
B. 06/06/13: Regular Meeting of the CalOptima Board of Directors
C. 11/05/09: Regular Meeting of the CalOptima Board of Directors
D. 11/06/08: Regular Meeting of the CalOptima Board of Directors
E. 10/02/08: Regular Meeting of the CalOptima Board of Directors
F. 06/03/08: Regular Meeting of the CalOptima Board of Directors
G. 12/04/07: Regular Meeting of the CalOptima Board of Directors
H. 06/05/07: Regular Meeting of the CalOptima Board of Directors
I. 06/04/02: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2007	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2009	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2011	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	06/01/2013	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	03/01/2015	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	04/01/2016	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	06/01/2017	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	10/04/2018	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group	Medi-Cal

IX. GLOSSARY

Term	Definition
Border Hospital	Those hospitals located outside the State of California that are within 55 miles' driving distance from the nearest physical at which a road crosses the California border as defined by the U.S. Geological Survey.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations, Sections 41515.2 through 41518.9.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
Certified Nurse Midwife	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code with additional training as a midwife who is certified to deliver infants and provide prenatal and postpartum care, newborn care, and some routine care of woman.
Certified Nurse Practitioner	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program conforms to board standards as specified in Title 16 California Code of Regulations, Section 1484.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, California Code of Regulations (CCR), Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, 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.

Term	Definition
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and IUCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
Federally Qualified Health Center	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
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.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	For purposes of this policy, a person or institution that furnishes Covered Services to Members.

Term	Definition
Qualified Family Planning Provider	A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to an enrollee as specified in Title 22, California Code of Regulations, Section 51200. A Physician, Physician Assistant (under the supervision of a Physician), Certified Nurse Midwife, and Nurse Practitioner are authorized to dispense medications. Pursuant to California Business and Professions Code section 2725.2, if these contraceptives are dispensed by a Registered Nurse (RN), the RN must have completed required training pursuant to Business and Professions Code section 2725.2 and the contraceptives must be billed with Evaluation and Management (E&M) procedure codes 99201, 99211, or 99212 with modifier TD (TD modifier as used for RN for (Behavioral Health) as found in the Medi-Cal Provider Manual.
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

1

Policy #:	GG.1101
Title:	**California Children's Services Whole Child Model**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/95
Last Review Date:	~~11/01/17~~10/04/18
Last Revised Date:	~~11/01/17~~10/04/18

I. PURPOSE

This policy defines the guidelines for coordination of care between CalOptima or a Health Network and ~~California Children's Services (CCS) for Children with Special Health Care Needs.~~the local California Children's Services (CCS) Program for Members eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model (WCM) program, newly CCS-eligible Members, or new CCS Members enrolling in CalOptima, including the identification and referral of Members with CCS-Eligible Conditions.

II. POLICY

A. ~~CCS provides medical~~Effective January 1, 2019, CalOptima or a Health Network shall assume responsibility for authorization and payment of CCS-eligible medical services, including authorization activities, claims processing and payment, case management, and quality oversight and coordination of all Medi-Cal and CCS-covered services, as well as Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), for Members eligible with the CCS Program and transitioned into the WCM program, newly CCS-eligible Members or new CCS Members enrolling in CalOptima, with the exception of those services that are the responsibility of the Department of Health Care Services (DHCS).

1. If a Member has Other Health Coverage (OHC), CalOptima and a Health Network shall consider the OHC plan as the Member's primary health plan. CalOptima and a Health Network shall remain the secondary health plan and payer of last resort in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

B. The local CCS Program maintains responsibility for the following:

a. CCS Program eligibility determination, including responding to and tracking appeals related to CCS Program medical eligibility determinations and redeterminations; and

~~A.~~b. Medical case management, physical and occupational therapy services, and financial assistance to Members under the age of twenty-one (21) who are eligible for CCS ~~services.~~.

~~B.~~C. CalOptima shall enter into a memorandum of understanding (MOU), or other agreement, with the local CCS ~~program~~Program for the coordination of CCS services to Members.

~~C.~~D. CalOptima, a Health Network, or a Practitioner~~,~~ shall identify Members who may have a CCS-Eligible Condition in accordance with this Policy.

~~D.~~E. CalOptima, a Health Network~~,~~ or a Practitioner~~,~~ shall refer a Member to the local CCS Program within twenty-four (24) hours, or the next working day, after determining that the Member may have a CCS-Eligible Condition.

~~E. A Member's Primary Care~~ CalOptima, a Health Network, or a Practitioner ~~(PCP), Health Network, or Practitioner,~~ shall refer ~~the Member to~~ all Members, including new Members, newly CCS ~~for Emergency Services that qualify under CCS within twenty-four (24) hours, or the next working day, after determining that the Member needs Emergency Services related to his or her~~ eligible Members, and WCM transition Members who may have developed a new CCS-Eligible Condition~~.~~

F. ~~CalOptima or a Health Network is~~, immediately to the local CCS Program for CCS eligibility determination and not ~~responsible for the provision or payment of services authorized by CCS for the treatment of a~~ wait until the annual CCS ~~Eligible Condition, after CCS determines that the Member is eligible for CCS~~ medical eligibility determination period.

~~1. CCS shall only reimburse CCS-paneled Providers and CCS-approved hospitals, for services authorized by CCS, for the treatment of a CCS-Eligible Condition.~~

G. CalOptima or a Health Network shall provide the following:

1. Provision and payment of Covered Services related to the identification, evaluation, and diagnosis of a CCS-Eligible Condition;

2. Medically Necessary Covered Services whether related or unrelated to a Member's CCS-Eligible Condition ~~after CCS determines that the Member is eligible for CCS~~;

~~3. Covered Services for a Member who has been referred to CCS, but is awaiting an eligibility determination, or authorization for service. The Covered Services may be related or unrelated to the Member's CCS-Eligible Condition; and~~

~~4. Covered Services for a Member if CCS does not approve eligibility, in accordance with Section III.E. of this policy.~~

~~H. CalOptima or a Health Network shall designate a case manager to serve as a liaison to CCS to help coordinate services with CCS.~~

3. CalOptima or a Health Network shall only authorize and reimburse CCS-paneled providers and CCS-approved facilities for the treatment of a CCS-Eligible Condition in accordance with CCS Program requirements and CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

H. CalOptima or a Health Network shall proactively ~~collaborate with CCS to~~ coordinate transition services for a WCM Member who loses Medi-Cal eligibility to the local CCS Program for ongoing health care and case management services.

I. CalOptima or a Health Network shall proactively coordinate services for a WCM Member reaching twenty-one (21) years of age ~~from CCS to CalOptima Direct, a Health Network, or~~ , including but not limited to those Members eligible for services with the Genetically Handicapped Persons

Program (GHPP~~).~~), in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model.

~~J. A Member or a Member's Authorized Representative shall have the right to decline enrollment in CCS after the Member is notified of his or her CCS eligibility.~~

J. CalOptima or a Health Network shall ensure the development of an Individual Care Plan, Case Management, care coordination, and risk stratification in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model.

K. CalOptima or a Health Network shall ensure access to out-of-network providers for eligible Members in order to obtain Medically Necessary services in accordance with CalOptima Policies GG.1325: Coordination of Care for Members With Expedited Health Care Needs and GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

L. CalOptima or a Health Network shall ensure the provision of the Maintenance and Transportation benefit for eligible Members and a Member's family seeking transportation to a medical service related to the Member's CCS-Eligible Condition in accordance with CalOptima Policy GG.1547: Maintenance and Transportation.

M. CalOptima and its Health Networks shall provide appropriate preventive, mental health, developmental, and specialty EPSDT medical services under the scope of the CalOptima program to eligible children under age twenty-one (21) years in accordance with CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

N. CalOptima shall ensure oversight of the functions and responsibilities, processes, and performance of a Health Network, including compliance with the requirements of the WCM program and network adequacy standards in accordance with CalOptima Policies GG.1619: Delegation Oversight and GG.1600: Access and Availability Standards.

III. PROCEDURE

A. A Practitioner shall perform appropriate baseline health assessments and diagnostic evaluations to identify potential CCS-Eligible Conditions in accordance with CalOptima Policy GG.1116: Pediatric Preventive Services.

B. CalOptima or a Health Network ~~may~~ shall provide training and resources to Practitioners and PCPs to ensure timely identification of Members with potential CCS-Eligible Conditions and notification to the local CCS Program.

~~B.~~C. CalOptima or a Health Network shall identify ~~a Member~~Members for CCS-Eligible Conditions through ~~a referral which may be made through,~~various means, including but ~~is~~ not limited to:

~~1. Utilization Management;~~

1. Screening of all requests for service authorizations for Medi-Cal Members under the age of twenty-one (21) by a trained team of nurses and medical authorization assistants;

~~2.~~ Screening of all Members referred for Case Management~~;~~

~~3. PCP;~~

~~4. Specialist;~~

~~5. Pharmacy;~~ and

~~6.~~ or Disease Management~~.~~

2. ~~CalOptima,~~ services or who are currently enrolled in a ~~Health Network, or a Practitioner,~~Case or Disease Management program; and

3. Review of pharmacy data.

~~C.~~D. CalOptima shall refer a Member to ~~CCS~~the local CCS Program for a medical eligibility determination after identifying ~~and determining~~ that the Member's medical condition may qualify him or her for CCS.

1. ~~CalOptima, a Health Network, or a~~A Practitioner~~,~~ shall refer a Member ~~to~~for CCS ~~by completing the following steps~~medical eligibility determination as follows:

~~A. Contacting the Member's PCP and requesting the Member's Medical Records;~~

~~b.~~a. ~~Ensuring the completion of~~Completing a Service Authorization Request (SAR) form~~,~~ ~~identifying which services the Member may be eligible for~~ or Health Network Authorization Request Form, and submitting the ~~SAR to the Orange County CCS office~~request to CalOptima; and

~~c.~~b. Ensuring the submission of all supporting medical documentation and information needed ~~by CCS to process the SAR~~to determine CCS medical eligibility and to determine the Medical Necessity of the services required.

~~D. If a Member is approved for CCS:~~

~~1. A~~ CalOptima ~~or Health Network case manager~~ shall ~~help coordinate~~facilitate the ~~Member's~~CCS medical eligibility determination by the local CCS ~~services.~~

~~2. A Member's PCP shall request authorization from CCS for CCS-authorized services.~~

~~E. If a Member is not approved for CCS:~~

~~1. A CalOptima, or Health Network, case manager may resubmit the Member's application, with additional information, for reconsideration. The application for reconsideration shall be reviewed~~Program by submitting the SAR/Authorization Request Form and ~~approved by a CalOptima or Health Network Medical Director prior~~supporting medical documentation to ~~submission.~~

~~2. If a Member is denied CCS for a second (2nd) time, CalOptima, or a Health Network, shall provide, and pay for, the Member's Covered Services.~~

~~F.~~2. ~~If CCS denies authorization because~~ the ~~Member does not have a CCS-Eligible Condition, or the service is not a benefit under CCS, the Member's Practitioner shall submit the authorization request and a copy of the CCS denial letter to CalOptima's Utilization Management (UM) Department, or the Member's Health Network~~local CCS Program.

~~G. CCS shall contact a Member, and his or her family, one hundred eighty (180) calendar days prior to the date the Member reaches twenty-one (21) years of age to inform the Member that his or her enrollment in CCS will automatically terminate on the date the Member reaches twenty-one (21) years of age. CCS shall provide a copy of the notice to CalOptima, or the Member's Health Network, to help transition the Member's services from CCS to CalOptima Direct, a Health Network, or the GHPP.~~

~~H. CalOptima, or a Member's Health Network, shall contact a Member at least one hundred twenty (120) calendar days prior to the Member reaching twenty-one (21) years of age to help transition services from CCS to CalOptima Direct, a Health Network, or GHPP.~~

E. The local CCS Program will provide confirmation or adverse determination of CCS medical eligibility to CalOptima, in accordance with CCS Program eligibility requirements.

1. CalOptima shall ensure notification of the CCS medical eligibility determination to the requesting Provider or Health Network.

2. Disagreements between CalOptima and the local CCS Program regarding CCS medical eligibility determinations must be resolved by the local CCS program, in consultation with DHCS. The local CCS Program shall communicate all resolved disputes in writing to CalOptima within a timely manner. Disputes between CalOptima and the local CCS Program that are unable to be resolved will be referred by either entity to DHCS.

3. Members appealing a CCS eligibility determination must appeal to the local CCS program.

F. Member Grievances

1. CalOptima shall ensure Members are provided information on and are provided the same grievances, appeals and state fair hearing rights in accordance with CalOptima Policies HH.1102: CalOptima Member Compliant, HH.1108: State Hearing Process, and GG.1510: Appeals Process for Decisions Regarding Care and Services.

G. Provider Grievances

1. A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the CalOptima or Health Network directly to CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint. CalOptima or a Health Network shall communicate the resolution process to all of its CCS providers.

IV. ATTACHMENTS

~~a. Application to Determine CCS Program Eligibility~~
~~B.~~A. New Referral CCS~~/GHPP~~ Client Service Authorization Request (SAR)

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Contract for Health Care Services
C. CalOptima Memorandum of Understanding with Orange County Health Care Agency for Whole Child Model

~~C.~~D. CalOptima Coordination and Provision of Public Health Care Services Contract with Orange County Health Care Agency
~~D.~~E. CalOptima Health Network Service Agreement
~~E.~~F. Title 22, California Code of Regulations (CCR), §§41515.2 through 41518.9
G. California Welfare and Institutions Code §§14093.06(b) and 14094.15(d)
H. CalOptima Policy GG.1116: Pediatric Preventive Services
I. CalOptima Policy GG.1325: Coordination of Care for Members With Expedited Health Care Needs
J. CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model
K. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
L. CalOptima Policy GG.1508: Authorization and Processing of Referrals
M. CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services
N. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
O. CalOptima Policy GG.1547: Maintenance and Transportation
P. CalOptima Policy GG.1600: Access and Availability Standards
Q. CalOptima Policy GG.1619: Delegation Oversight
R. CalOptima Policy HH.1101: CalOptima Provider Complaint
S. CalOptima Policy HH.1102: CalOptima Member Complaint
T. CalOptima Policy HH.1108: State Hearing Process
U. CalOptima Policy FF.2003: Coordination of Benefits
V. Department of Health Care Services (DHCS) All Plan Letter 18-011: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVALS

A. 12/10/15: Department of Health Care Services

VII. BOARD ACTIONS

~~None to Date~~A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/1999	GG.1101	California Children's Services	Medi-Cal
Revised	05/01/2000	GG.1101	California Children's Services	Medi-Cal
Revised	04/01/2007	GG.1101	California Children's Services	Medi-Cal
Revised	08/01/2009	GG.1101	California Children's Services	Medi-Cal
Revised	09/01/2014	GG.1101	California Children's Services	Medi-Cal
Revised	09/01/2015	GG.1101	California Children's Services	Medi-Cal
Revised	10/01/2016	GG.1101	California Children's Services	Medi-Cal
Revised	11/01/2017	GG.1101	California Children's Services	Medi-Cal
Revised	10/04/2018	GG.1101	California Children's Services/Whole Child Model	Medi-Cal

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: Access by a Member's Authorized Representative.~~
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible ~~children~~individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services Eligible Conditions	~~Include, but are not limited to: chronic~~Chronic medical conditions ~~such as~~, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae~~.~~ as defined in Title 22, California Code of Regulations sections41515.2 through 41518.9.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Case Management	A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
Children with Special Health Care Needs	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.

Term	Definition
~~Emergency Services~~Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)	~~Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.~~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.
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.
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.
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.
Other Health Coverage	The responsibility of an individual or entity, other than CalOptima or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.

Term	Definition
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, or eligible for the Whole Child Model program, "Primary Care Practitioner" or "PCP" shall additionally mean any ~~Specialist Physician~~Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialist or clinic ~~in accordance with W & I Code 14182(b)(11).~~.

1

Policy #:	GG.1101
Title:	**California Children's Services Whole Child Model**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/95
Last Review Date:	10/04/18
Last Revised Date:	10/04/18

I. PURPOSE

This policy defines the guidelines for coordination of care between CalOptima or a Health Network and the local California Children's Services (CCS) Program for Members eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model (WCM) program, newly CCS-eligible Members, or new CCS Members enrolling in CalOptima, including the identification and referral of Members with CCS-Eligible Conditions.

II. POLICY

A. Effective January 1, 2019, CalOptima or a Health Network shall assume responsibility for authorization and payment of CCS-eligible medical services, including authorization activities, claims processing and payment, case management, and quality oversight and coordination of all Medi-Cal and CCS-covered services, as well as Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), for Members eligible with the CCS Program and transitioned into the WCM program, newly CCS-eligible Members or new CCS Members enrolling in CalOptima, with the exception of those services that are the responsibility of the Department of Health Care Services (DHCS).

1. If a Member has Other Health Coverage (OHC), CalOptima and a Health Network shall consider the OHC plan as the Member's primary health plan. CalOptima and a Health Network shall remain the secondary health plan and payer of last resort in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

B. The local CCS Program maintains responsibility for the following:

a. CCS Program eligibility determination, including responding to and tracking appeals related to CCS Program medical eligibility determinations and redeterminations; and

b. Medical case management, physical and occupational therapy services, and financial assistance to Members under the age of twenty-one (21) who are eligible for CCS.

C. CalOptima shall enter into a memorandum of understanding (MOU), or other agreement, with the local CCS Program for the coordination of CCS services to Members.

D. CalOptima, a Health Network, or a Practitioner shall identify Members who may have a CCS-Eligible Condition in accordance with this Policy.

Back to Agenda

E. CalOptima, a Health Network or a Practitioner shall refer a Member to the local CCS Program within twenty-four (24) hours, or the next working day, after determining that the Member may have a CCS-Eligible Condition.

F. CalOptima, a Health Network, or a Practitioner shall refer all Members, including new Members, newly CCS-eligible Members, and WCM transition Members who may have developed a new CCS-Eligible Condition, immediately to the local CCS Program for CCS eligibility determination and not wait until the annual CCS medical eligibility determination period.

G. CalOptima or a Health Network shall provide the following:

1. Provision and payment of Covered Services related to the identification, evaluation, and diagnosis of a CCS-Eligible Condition;

2. Medically Necessary Covered Services whether related or unrelated to a Member's CCS-Eligible Condition;

3. CalOptima or a Health Network shall only authorize and reimburse CCS-paneled providers and CCS-approved facilities for the treatment of a CCS-Eligible Condition in accordance with CCS Program requirements and CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

H. CalOptima or a Health Network shall proactively coordinate transition services for a WCM Member who loses Medi-Cal eligibility to the local CCS Program for ongoing health care and case management services.

I. CalOptima or a Health Network shall proactively coordinate services for a WCM Member reaching twenty-one (21) years of age, including but not limited to those Members eligible for services with the Genetically Handicapped Persons Program (GHPP), in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model.

J. CalOptima or a Health Network shall ensure the development of an Individual Care Plan, Case Management, care coordination, and risk stratification in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model.

K. CalOptima or a Health Network shall ensure access to out-of-network providers for eligible Members in order to obtain Medically Necessary services in accordance with CalOptima Policies GG.1325: Coordination of Care for Members With Expedited Health Care Needs and GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

L. CalOptima or a Health Network shall ensure the provision of the Maintenance and Transportation benefit for eligible Members and a Member's family seeking transportation to a medical service related to the Member's CCS-Eligible Condition in accordance with CalOptima Policy GG.1547: Maintenance and Transportation.

M. CalOptima and its Health Networks shall provide appropriate preventive, mental health, developmental, and specialty EPSDT medical services under the scope of the CalOptima program to eligible children under age twenty-one (21) years in accordance with CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

N. CalOptima shall ensure oversight of the functions and responsibilities, processes, and performance of a Health Network, including compliance with the requirements of the WCM program and network adequacy standards in accordance with CalOptima Policies GG.1619: Delegation Oversight and GG.1600: Access and Availability Standards.

III. PROCEDURE

A. A Practitioner shall perform appropriate baseline health assessments and diagnostic evaluations to identify potential CCS-Eligible Conditions in accordance with CalOptima Policy GG.1116: Pediatric Preventive Services.

B. CalOptima or a Health Network shall provide training and resources to Practitioners and PCPs to ensure timely identification of Members with potential CCS-Eligible Conditions and notification to the local CCS Program.

C. CalOptima or a Health Network shall identify Members for CCS-Eligible Conditions through various means, including but not limited to:

1. Screening of all requests for service authorizations for Medi-Cal Members under the age of twenty-one (21) by a trained team of nurses and medical authorization assistants;

2. Screening of all Members referred for Case Management and or Disease Management services or who are currently enrolled in a Case or Disease Management program; and

3. Review of pharmacy data.

D. CalOptima shall refer a Member to the local CCS Program for a medical eligibility determination after identifying that the Member's medical condition may qualify him or her for CCS.

1. A Practitioner shall refer a Member for CCS medical eligibility determination as follows:

a. Completing a Service Authorization Request (SAR) form or Health Network Authorization Request Form, and submitting the request to CalOptima; and

b. Ensuring the submission of all supporting medical documentation and information needed to determine CCS medical eligibility and to determine the Medical Necessity of the services required.

2. CalOptima shall facilitate the CCS medical eligibility determination by the local CCS Program by submitting the SAR/Authorization Request Form and supporting medical documentation to the local CCS Program.

E. The local CCS Program will provide confirmation or adverse determination of CCS medical eligibility to CalOptima, in accordance with CCS Program eligibility requirements.

1. CalOptima shall ensure notification of the CCS medical eligibility determination to the requesting Provider or Health Network.

2. Disagreements between CalOptima and the local CCS Program regarding CCS medical eligibility determinations must be resolved by the local CCS program, in consultation with DHCS. The local CCS Program shall communicate all resolved disputes in writing to

CalOptima within a timely manner. Disputes between CalOptima and the local CCS Program that are unable to be resolved will be referred by either entity to DHCS.

3. Members appealing a CCS eligibility determination must appeal to the local CCS program.

F. Member Grievances

1. CalOptima shall ensure Members are provided information on and are provided the same grievances, appeals and state fair hearing rights in accordance with CalOptima Policies HH.1102: CalOptima Member Compliant, HH.1108: State Hearing Process, and GG.1510: Appeals Process for Decisions Regarding Care and Services.

G. Provider Grievances

1. A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the CalOptima or Health Network directly to CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint. CalOptima or a Health Network shall communicate the resolution process to all of its CCS providers.

IV. ATTACHMENTS

A. New Referral CCS Client Service Authorization Request (SAR)

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Contract for Health Care Services
C. CalOptima Memorandum of Understanding with Orange County Health Care Agency for Whole Child Model
D. CalOptima Coordination and Provision of Public Health Care Services Contract with Orange County Health Care Agency
E. CalOptima Health Network Service Agreement
F. Title 22, California Code of Regulations (CCR), §§41515.2 through 41518.9
G. California Welfare and Institutions Code §§14093.06(b) and 14094.15(d)
H. CalOptima Policy GG.1116: Pediatric Preventive Services
I. CalOptima Policy GG.1325: Coordination of Care for Members With Expedited Health Care Needs
J. CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model
K. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
L. CalOptima Policy GG.1508: Authorization and Processing of Referrals
M. CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services
N. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
O. CalOptima Policy GG.1547: Maintenance and Transportation
P. CalOptima Policy GG.1600: Access and Availability Standards
Q. CalOptima Policy GG.1619: Delegation Oversight
R. CalOptima Policy HH.1101: CalOptima Provider Complaint
S. CalOptima Policy HH.1102: CalOptima Member Complaint
T. CalOptima Policy HH.1108: State Hearing Process
U. CalOptima Policy FF.2003: Coordination of Benefits

V. Department of Health Care Services (DHCS) All Plan Letter 18-011: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVALS

A. 12/10/15: Department of Health Care Services

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/1999	GG.1101	California Children's Services	Medi-Cal
Revised	05/01/2000	GG.1101	California Children's Services	Medi-Cal
Revised	04/01/2007	GG.1101	California Children's Services	Medi-Cal
Revised	08/01/2009	GG.1101	California Children's Services	Medi-Cal
Revised	09/01/2014	GG.1101	California Children's Services	Medi-Cal
Revised	09/01/2015	GG.1101	California Children's Services	Medi-Cal
Revised	10/01/2016	GG.1101	California Children's Services	Medi-Cal
Revised	11/01/2017	GG.1101	California Children's Services	Medi-Cal
Revised	10/04/2018	GG.1101	California Children's Services/Whole Child Model	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services Eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections41515.2 through 41518.9.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Case Management	A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
Children with Special Health Care Needs	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.
Early and Periodic Screening, Diagnosis and Treatment Services (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.

Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
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.
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.
Other Health Coverage	The responsibility of an individual or entity, other than CalOptima or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, or eligible for the Whole Child Model program, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialist or clinic.

1

NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number
4. Address (number, street)	City	State ZIP code
5. Contact person	6. Contact telephone number ( )	7. Contact fax number ( )

Client Information

8. Client name—last	first	middle
9. Alias (AKA)	10. Gender ☐ Male ☐ Female	11. Date of birth (mm/dd/yy)
12. CCS/GHPP case number	13. Medical record number (hospital or office)	14. Home phone number ( )
15. Cell phone number ( )	16. Work phone number ( )	17. Email address
18. Residence address (number, street) *(DO NOT USE P.O. BOX)*	City	State ZIP code
19. Mailing address (if different) (number, street, P.O. box number)	City	State ZIP code
20. County of residence	21. Language spoken	22. Name of parent/legal guardian
23. Mother's first name	24. Primary care physician (if known)	25. Primary care physician telephone number ( )

Insurance Information

26.a. Enrolled in Medi-Cal? ☐ Yes ☐ No	26.b. If yes, client index number (CIN)	26.c. Client's Medi-Cal number
27. Enrolled in commercial insurance plan ☐ Yes ☐ No	If yes, type of commercial insurance plan ☐ PPO ☐ HMO ☐ Other	Name of plan

Diagnosis

28.
Diagnosis (DX)/ICD-10:_____ DX/ICD-10:_____ DX/ICD-10: _____

Requested Services

29.* CPT-4/ HCPCS Code/NDC	30. Specific Description of Service/Procedure	31. From (mm/dd/yy)	To (mm/dd/yy)	32. Frequency/ Duration	33. Units	34. Quantity (Pharmacy Only)

* A specific procedure code/NDC is required in column 27 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

35. Other documentation attached ☐ Yes	36. Enter facility name (where requested services will be performed, if other than office).

Inpatient Hospital Services

37. Begin date	38. End date	39. Number of days

Additional Services Requested from Other Health Care Provider

40. **Provider's name**	Provider number	Telephone number ( )	Contact person
Address (number, street)	City	State	ZIP code

Description of services	Procedure code	Units	Quantity
Addi ional information			

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not be processed.

41. Signature of physician/provider or authorized designee	42. Date

Back to Agenda

Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter National Provider Identification (NPI) number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Alias (AKA): Enter the patient's alias, if known.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS/GHPP case number: Enter the client's California Children's Services (CCS)/Genetically Handicapped Persons Program (GHPP) number. If not known, leave blank.
13. Medical record number: Enter the client's hospital or office medical record number.
14. Home phone number: Enter the home phone number where the client or client's legal guardian can be reached.
15. Cell phone number: Enter the cellular phone number where the client or client's legal guardian can be reached.
16. Work phone number: Enter the work phone number where the client or client's legal guardian can be reached.
17. Email address: Enter the email address of the client or client's legal guardian.
18. Residence address: Enter the address of the client. Do not use a P.O. Box number.
19. Mailing address: Enter the mailing address if it is different than number 18.
20. County of residence: Enter residential county of the client.
21. Language spoken: Enter the client's language spoken.
22. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
23. Mother's first name: Enter the client's mother's first name.
24. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).
25. Primary care physician telephone number: Enter the client's primary care physician phone number.

Insurance Information

26a. Enrolled in Medi-Cal? Mark the appropriate box. If the answer is yes, enter the client's index number in box 26.b. and the client's Medi-Cal number in box 26.c.

27. Enrolled in a commercial insurance plan? Mark the appropriate box, if the answer is yes, mark the type of insurance plan and enter the name of the commercial insurance plan on the line provided.

Diagnosis

28. Diagnosis and/or ICD-10: Enter the diagnosis or ICD-10 code, if known, relating to the requested services.

Requested Services

29. CPT-4/HCPCS code/NDC: Enter the CPT-4, HCPCS code or NDC code being requested. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
30. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
31. From and to dates: Enter the date you would l ke the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
32. Frequency/duration: Enter the frequency or duration of the procedures/service being requested.
33. Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
34. Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
35. Other documentation attached: Check this box if attaching additional documentation.
36. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

37. Begin date: Enter the date the requested inpatient stay shall begin.
38. End date: Enter the end date for the inpatient stay requested.
39. Number of days: Enter the number of days for the requested inpatient stay.

Additional Services Requested from Other Health Care Providers

40. Provider's name: Enter name of the provider you are referring services to.
Provider number: Enter the provider's National Provider Identification (NPI) number. Telephone: Enter provider's telephone number.
Contact person: Enter the name of the person who can be contacted regarding the request. Address: Enter address of the provider.
Description of services: Enter description of referred services.
Procedure code: Enter the procedure code for requested service other than ongoing physician services.
Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
Additional information: Include any written instructions/details here.

Signature

41. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
42. Date: Enter the date the request is signed.

Back to Agenda

Policy #:	GG.1112
Title:	**Standing Referral to Specialty Care Provider or Specialty Care Center**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/99
Last Review Date:	~~03/01/17~~10/04/18
Last Revised Date:	~~03/01/17~~10/04/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy defines the conditions under which CalOptima and its Health Networks shall authorize a Standing Referral to a Specialty Care Provider or a Specialty Care Center.

II. POLICY

A. CalOptima and its Health Networks may authorize a Standing Referral for a Member who requires treatment for a medical condition or disease that is life threatening, degenerative, or disabling, and that requires specialized medical care over a prolonged period, including, but not limited to, a Member diagnosed with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS).

B. Subject to the provisions of this policy, CalOptima or a Health Network may authorize a Standing Referral for a Member if the Member's Primary Care Practitioner (PCP), in consultation with the Health Network or CalOptima Medical Director and a Specialty Care Provider or Specialty Care Center, determines that the Member needs continuing care from a Specialty Care Provider or a Specialty Care Center.

C. A Member, Authorized Representative, Primary Care Physician (PCP), or Specialty Care Provider may submit a request for a Standing Referral or Extended Referral to CalOptima.

D. If CalOptima or a Health Network determines that a Standing Referral is necessary, CalOptima or the Health Network shall make the referral according to a treatment plan approved by CalOptima or the Health Network in consultation with the PCP, Specialty Care Provider or Specialty Care Center, and the Member.

E. An authorization for a Standing Referral to a Specialty Care Provider or Specialty Care Center may:

1. Designate the duration of continuing care;

2. Require communication between the Specialty Care Provider or Specialty Care Center and the Member's PCP or the CalOptima Medical Director; and/or

3. Delineate the process by which the Member, Authorized Representative, PCP, or Specialty Care Provider or Specialty Care Center may request additional referrals, as needed.

F. This policy does not require CalOptima or a Health Network to authorize a referral to a Specialty Care Provider or Specialty Care Center that is not employed or contracted with CalOptima or the Health Network to provide Covered Services to Members, unless there is no Specialty Care Provider or Specialty Care Center within the network that is qualified to provide the specialty care to the Member.

G. ~~CalOptima and a Health Network is not responsible~~When the requirements for ~~authorizing~~ a Standing Referral ~~if~~for the treatment of California Children's Services (CCS) ~~program authorizes the Specialty Care Provider~~Program-Eligible Conditions are meet for CCS-eligible Members n the Whole Child Model program, Standing Referrals shall only be made by CalOptima or a Health Network to CCS paneled providers or Specialty Care Center ~~service, including services for a CCS-eligible Member diagnosed with HIV or AIDS.~~ qualified to treat the CCS-Eligible Condition.

III. PROCEDURE

A. A Member's PCP and Specialty Care Provider or Specialty Care Center shall develop a treatment plan with the Member's participation. The treatment plan may limit the number of visits to the Specialty Care Provider or Specialty Care Center, define the services authorized, or limit the period of time for which the visits are authorized.

B. CalOptima or a Health Network may waive the requirement for a treatment plan if it approves an existing Standing Referral to a Specialty Care Provider or Specialty Care Center.

~~A.~~C. A request for a Standing Referral shall include:

1. Member's diagnosis;

2. Required treatment;

3. Requested frequency and duration of care from the Specialty Care Provider or Specialty Care Center; and

4. Relevant clinical information to support the request.

~~C.~~D. Upon request from a Member's PCP or a Specialty Care Provider for a Standing Referral, the following shall occur:

1. CalOptima or a Health Network shall make a determination on the Standing Referral request within three (3) business days after receipt of the appropriate medical records and other information necessary to evaluate the request;

2. CalOptima or a Health Network shall notify the Member, the Member's PCP, or the Specialty Care Provider or Specialty Care Center of a decision to deny, defer, modify, or terminate a request for a Standing Referral in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization; and

3. Upon approval of a request for a Standing Referral, CalOptima or a Health Network shall provide the referral to the approved Specialty Care Provider or Specialty Care Center within four (4) business days after the determination.

~~D.~~E. A Specialty Care Provider shall provide a Member's PCP with regular reports on the health care provided to the Member in accordance with CalOptima Policy GG.1113: ~~Referral~~Specialty Practitioner Responsibilities, and the conditions outlined in this policy.

F. A Provider or Practitioner shall obtain authorization for Covered Services for Members enrolled in CalOptima Direct (COD)-Administrative or CalOptima Community Network (CCN) in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

G. A Provider or Practitioner shall obtain authorization for Covered Services for Members enrolled in a Health Network in accordance with the Health Network's authorization rules. s.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Policy GG.1113: ~~Referral~~Specialty Practitioner Responsibilities
E. CalOptima Policy GG.1500: Authorization Instructions for COD and CalOptima Community Network Providers
~~E.~~F. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
~~F.~~G. CalOptima Three-way Contract with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
~~G.~~H. Health and Safety Code, Section 1374.16
~~H.~~I. Title 42, Code of Federal Regulations (C.F.R), Section 438.208(c)(4)

VI. REGULATORY AGENCY APPROVALS

A. 03/28/16: Department of Health Care Services

VII. BOARD ACTIONS

~~Not Applicable~~A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/01/1999	GG.1112	Standing Referral to Specialist Practitioner or Specialty Care Center	Medi-Cal
Revised	06/01/2007	GG.1112	Standing Referral to Specialist Practitioner or Specialty Care Center	Medi-Cal
Revised	11/01/2015	GG.1112	Standing Referral to Specialty Care Provider or Specialty Care Center	Medi-Cal OneCare OneCare Connect
Revised	02/01/2016	GG.1112	Standing Referral to Specialty Care Provider or Specialty Care Center	Medi-Cal OneCare OneCare Connect
Revised	03/01/2017	GG.1112	Standing Referral to Specialty Care Provider or Specialty Care Center	Medi-Cal OneCare OneCare Connect
Revised	10/04/2018	GG.1112	Standing Referral to Specialty Care Provider or Specialty Care Center	Medi-Cal OneCare OneCare Connect

1

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.
California Children Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible ~~children~~individuals under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible ~~Conditions~~Condition	~~Conditions~~Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae defined in Title 22, California Code of Regulations sections41515.2 through 41518.9. ~~, Sec4187, 6 including, but not limited to~~ ~~1. Infectious and parasitic diseases;~~ ~~2. Neoplasms;~~ ~~3. Endocrine, nutritional, and metabolic diseases;~~ ~~4. Disease of blood and blood forming organs~~ ~~5. Diseases of the nervous system;~~ ~~6. Diseases of the eye;~~ ~~7. Diseases of the ear and mastoid process;~~ ~~8. Diseases of the circulatory system;~~ ~~9. Diseases of the respiratory system;~~ ~~10. Diseases of the digestive system;~~ ~~11. Diseases of the genitourinary system;~~ ~~12. Complications of pregnancy, childbirth, and puerperium;~~ ~~13. Diseases of the skin and subcutaneous tissue;~~ ~~14. Diseases of the musculoskeletal and connective tissue;~~ ~~15. Congenital anomalies;~~ ~~16. Certain causes of perinatal morbidity and mortality; and~~ ~~17. Accidents, poisonings, violence, and immunization reactions.~~tion 41800..

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, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: 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 Centers of Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) Three-Way Contract.
Extended Referral	A referral to a specialist for more than one (1) visit, where the Member's condition or disease requires specialized medical care over a prolonged period of time and is life-threatening, degenerative or disabling, and requires a specialist to coordinate the Member's health care (including some or all primary care).
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC~~), Physician Medical Group (PMG),),~~ physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialist or clinic ~~in accordance with W & I Code 14182(b)(11).~~
Specialty Care Center	A center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Term	Definition
Specialty Care Provider	A physician who has obtained additional education/training in a focused clinical area and does not function as a PCP.
Standing Referral	A referral to a specialist for more than one (1) visit, as indicated in an Active Treatment Plan, if any, without the Provider having to provide a specific referral for each visit.

1

Policy #:	GG.1112
Title:	**Standing Referral to Specialty Care Provider or Specialty Care Center**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/99
Last Review Date:	10/04/18
Last Revised Date:	10/04/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy defines the conditions under which CalOptima and its Health Networks shall authorize a Standing Referral to a Specialty Care Provider or a Specialty Care Center.

II. POLICY

A. CalOptima and its Health Networks may authorize a Standing Referral for a Member who requires treatment for a medical condition or disease that is life threatening, degenerative, or disabling, and that requires specialized medical care over a prolonged period, including, but not limited to, a Member diagnosed with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS).

B. Subject to the provisions of this policy, CalOptima or a Health Network may authorize a Standing Referral for a Member if the Member's Primary Care Practitioner (PCP), in consultation with the Health Network or CalOptima Medical Director and a Specialty Care Provider or Specialty Care Center, determines that the Member needs continuing care from a Specialty Care Provider or a Specialty Care Center.

C. A Member, Authorized Representative, Primary Care Physician (PCP), or Specialty Care Provider may submit a request for a Standing Referral or Extended Referral to CalOptima.

D. If CalOptima or a Health Network determines that a Standing Referral is necessary, CalOptima or the Health Network shall make the referral according to a treatment plan approved by CalOptima or the Health Network in consultation with the PCP, Specialty Care Provider or Specialty Care Center, and the Member.

E. An authorization for a Standing Referral to a Specialty Care Provider or Specialty Care Center may:

1. Designate the duration of continuing care;

2. Require communication between the Specialty Care Provider or Specialty Care Center and the Member's PCP or the CalOptima Medical Director; and/or

3. Delineate the process by which the Member, Authorized Representative, PCP, or Specialty Care Provider or Specialty Care Center may request additional referrals, as needed.

F. This policy does not require CalOptima or a Health Network to authorize a referral to a Specialty Care Provider or Specialty Care Center that is not employed or contracted with CalOptima or the Health Network to provide Covered Services to Members, unless there is no Specialty Care Provider or Specialty Care Center within the network that is qualified to provide the specialty care to the Member.

G. When the requirements for a Standing Referral for the treatment of California Children's Services (CCS) Program-Eligible Conditions are meet for CCS-eligible Members n the Whole Child Model program, Standing Referrals shall only be made by CalOptima or a Health Network to CCS paneled providers or Specialty Care Center qualified to treat the CCS-Eligible Condition.

III. PROCEDURE

A. A Member's PCP and Specialty Care Provider or Specialty Care Center shall develop a treatment plan with the Member's participation. The treatment plan may limit the number of visits to the Specialty Care Provider or Specialty Care Center, define the services authorized, or limit the period of time for which the visits are authorized.

B. CalOptima or a Health Network may waive the requirement for a treatment plan if it approves an existing Standing Referral to a Specialty Care Provider or Specialty Care Center.

C. A request for a Standing Referral shall include:

1. Member's diagnosis;

2. Required treatment;

3. Requested frequency and duration of care from the Specialty Care Provider or Specialty Care Center; and

4. Relevant clinical information to support the request.

D. Upon request from a Member's PCP or a Specialty Care Provider for a Standing Referral, the following shall occur:

1. CalOptima or a Health Network shall make a determination on the Standing Referral request within three (3) business days after receipt of the appropriate medical records and other information necessary to evaluate the request;

2. CalOptima or a Health Network shall notify the Member, the Member's PCP, or the Specialty Care Provider or Specialty Care Center of a decision to deny, defer, modify, or terminate a request for a Standing Referral in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization; and

3. Upon approval of a request for a Standing Referral, CalOptima or a Health Network shall provide the referral to the approved Specialty Care Provider or Specialty Care Center within four (4) business days after the determination.

E. A Specialty Care Provider shall provide a Member's PCP with regular reports on the health care provided to the Member in accordance with CalOptima Policy GG.1113: Specialty Practitioner Responsibilities, and the conditions outlined in this policy.

F. A Provider or Practitioner shall obtain authorization for Covered Services for Members enrolled in CalOptima Direct (COD)-Administrative or CalOptima Community Network (CCN) in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

G. A Provider or Practitioner shall obtain authorization for Covered Services for Members enrolled in a Health Network in accordance with the Health Network's authorization rules. s.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Policy GG.1113: Specialty Practitioner Responsibilities
E. CalOptima Policy GG.1500: Authorization Instructions for COD and CalOptima Community Network Providers
F. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
G. CalOptima Three-way Contract with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
H. Health and Safety Code, Section 1374.16
I. Title 42, Code of Federal Regulations (C.F.R), Section 438.208(c)(4)

VI. REGULATORY AGENCY APPROVALS

A. 03/28/16: Department of Health Care Services

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/01/1999	GG.1112	Standing Referral to Specialist Practitioner or Specialty Care Center	Medi-Cal
Revised	06/01/2007	GG.1112	Standing Referral to Specialist Practitioner or Specialty Care Center	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	11/01/2015	GG.1112	Standing Referral to Specialty Care Provider or Specialty Care Center	Medi-Cal OneCare OneCare Connect
Revised	02/01/2016	GG.1112	Standing Referral to Specialty Care Provider or Specialty Care Center	Medi-Cal OneCare OneCare Connect
Revised	03/01/2017	GG.1112	Standing Referral to Specialty Care Provider or Specialty Care Center	Medi-Cal OneCare OneCare Connect
Revised	10/04/2018	GG.1112	Standing Referral to Specialty Care Provider or Specialty Care Center	Medi-Cal OneCare OneCare Connect

1

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.3009.
California Children Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae defined in Title 22, California Code of Regulations sections41515.2 through 41518.9. tion 41800..
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, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: 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 Centers of Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) Three-Way Contract.
Extended Referral	A referral to a specialist for more than one (1) visit, where the Member's condition or disease requires specialized medical care over a prolonged period of time and is life-threatening, degenerative or disabling, and requires a specialist to coordinate the Member's health care (including some or all primary care).
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.

Term	Definition
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialist or clinic.
Specialty Care Center	A center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.
Specialty Care Provider	A physician who has obtained additional education/training in a focused clinical area and does not function as a PCP.
Standing Referral	A referral to a specialist for more than one (1) visit, as indicated in an Active Treatment Plan, if any, without the Provider having to provide a specific referral for each visit.

1

Policy #:	GG.1325
Title:	~~Coordination~~**Continuity of Care for ~~Newly Enrolled Medi-Cal~~ Members Transitioning into CalOptima Services**
Department:	Medical Affairs
Section:	Case Management
CEO Approval:	Michael Schrader
Effective Date:	01/01/15
Review Date:	~~11/01/17~~10/04/18
Revised Date:	~~11/01/17~~10/04/18

I. PURPOSE

This policy establishes the Continuity of Care guidelines and the process ~~for identifying~~to identify Members who have expedited care needs for newly enrolled Medi-Cal Members who transition into CalOptima~~.~~ or existing Members whose Covered Services are transitioned from Medi-Cal Fee-for-Service (FFS) to CalOptima.

II. POLICY

A. Effective July 1, 2017, CalOptima shall screen all new Members for the need for expedited services upon their enrollment into CalOptima as described in Section III.B. of this Policy.

B. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. Upon request from the Member, and in accordance with this Policy, CalOptima or a Health Network shall ensure Continuity of Care for a Medi-Cal beneficiary transitioning from Medi-Cal ~~Fee-For-Service (~~FFS~~), or~~, another Medi-Cal Managed Care Plan, or existing Members whose Covered Services are transitioned from Medi-Cal FFS to CalOptima, with his or her ~~out~~Existing Out-of-~~network nursing facility, Primary Care Practitioner (PCP), or Specialty Care~~Network Provider~~,~~ for a period of no more than twelve (12) months, unless otherwise provided in Section III.C. of this Policy, ~~from the date of the Member's transition into CalOptima,~~ if the following criteria are met:

1. ~~The~~A Member has an existing relationship with one (1) of the ~~nursing facility or Provider. An~~ following. There is an existing relationship ~~requires~~with:

~~1.~~a. An out-of-network Primary Care Practitioner (PCP) or Specialty Care Provider if the Member ~~having~~has seen the out-of-network PCP, or Specialty Care Provider for a non-emergency visit at least once during the twelve (12) months prior to the date of enrollment in CalOptima ~~for a PCP, Behavioral Health Treatment (BHT) provider, or all other Specialty Care Providers~~;

~~The~~ b. An out-of-network Behavioral Health Treatment (BHT) Service Provider if the Member has seen the out-of-network BHT Service Provider for a non-emergency visit at least once during the six (6) months prior to either the transition of services from the Regional Center of Orange County (RCOC) to CalOptima or the date of the Member's initial enrollment in CalOptima if the enrollment occurred on or after July 1, 2018;

b. An out-of-network nursing facility~~, PCP, or~~ if the Member has resided in the out-of-network nursing facility prior to enrollment in CalOptima, or prior to receiving long term care benefits from CalOptima; and

c. A County Mental Health Plan Provider for non-specialty mental health services in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive Specialty ~~Care~~Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima.

2. The Existing Out-of-Network Provider~~,~~ will accept CalOptima, or Medi-Cal FFS rates, whichever is higher;

3. The ~~nursing facility, PCP, or Specialty Care~~Existing Out-of-Network Provider~~,~~ meets applicable professional standards and has no disqualifying quality of care issues;

4. ~~The nursing facility, PCP or Specialty Care~~The Existing Out-of-Network Provider has not been terminated, suspended, or decertified from the Medi-Cal program by DHCS;

5. The ~~nursing facility, PCP, or Specialty Care~~Existing Out-of-Network Provider~~,~~ is a California State Plan-approved provider;

6. The ~~nursing facility, PCP or Specialty Care~~Existing Out-of-Network Provider supplies CalOptima with all relevant assessment, diagnosis, and treatment information, for the purposes of determining Medical Necessity, as well as a current treatment plan as allowed under federal and state privacy laws and regulations; and

7. The Member, Authorized Representative of the Member, or the ~~PCP or Specialty Care~~Existing Out-of-Network Provider~~, request~~ requests Continuity of Care. For a Member residing in an out-of-network nursing facility prior to enrollment in CalOptima or receiving BHT services at RCOC, Continuity of Care is guaranteed and need not be requested.

D. CalOptima or a Health Network shall provide Continuity of Care for a Member ~~with the Member's out-of-network PCP, or Specialty Care Provider~~as described in this Policy, except for the following types of providers:

~~1. Durable Medical Equipment (DME);~~
1. Durable Medical Equipment (DME), excluding Specialized or Customized DME for Members eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model (WCM) program as described in Section III.O.8.b.i. of this Policy;

2. Transportation; and

3. ~~Ancillary~~Other ancillary services.

E. CalOptima and Health Networks are also required to comply with existing state law Continuity of Care obligations which may allow a Medi-Cal beneficiary a longer period of treatment by an out-of-network provider than would be required under DHCS All Plan Letter 18-008~~:~~ (Revised).: Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care.

F. CalOptima or a Health Network shall not provide Continuity of Care for:

1. Services not covered by Medi-Cal; and

2. Services carved-out of CalOptima's contract with the Department of Health Care Services (DHCS).

G. If a Member changes Medi-Cal Managed Care Plans (MCP), the twelve (12) month Continuity of Care period may start over one (1) time. If a Member changes MCPs a second time (or more), the Continuity of Care period does not start over, meaning that the Member does not have the right to a new twelve (12) months of Continuity of Care. If a beneficiary changes MCPs, this Continuity of Care Policy does not extend to providers that the beneficiary accessed through their previous MCP. If the Member returns to Medi-Cal FFS and later reenrolls in CalOptima, the Continuity of Care period does not start over, but may be completed only if the Member:

1. Returned to FFS for less than the twelve (12) month Continuity of Care period; and

2. Was eligible for and elected to receive Continuity of Care during the previous CalOptima enrollment period.

H. An approved ~~out-of-network nursing facility, PCP or Specialty Care~~Existing Out-of-Network Provider must work with CalOptima and its contracted network and cannot refer the Member to another out-of-network provider without prior authorization from CalOptima or a Health Network.

I. CalOptima shall inform Members of the Continuity of Care protections and how to initiate a Continuity of Care request in written Member materials, including but not limited to, the Member Handbook, available by request and on the CalOptima website at www.caloptima.org, and Member newsletter.

J. CalOptima or a Health Network shall provide training to call center staff who come into regular contact with Members about the Continuity of Care protections.

III. PROCEDURE

A. CalOptima shall include a health information form in each New Member Welcome Packet mailing with a postage paid envelope.

1. If the Member does not respond to the mailed health information form, CalOptima shall make two (2) call attempts within ninety (90) calendar days to remind the Member to complete the form.

B. CalOptima shall conduct an initial screening of all responses received within ninety (90) calendar days of the Members' effective date(s) of enrollment.

1. Additional outreach and care coordination activities may occur in accordance with CalOptima Policies GG.1301: Comprehensive Case Management Process and GG.1209: Population –Based Care: Disease Management.

2. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. Upon request from the Member, and in accordance with the requirements of this Policy, CalOptima or a Health Network shall provide the completion of Covered Services by an out-of-network nursing facility, PCP, or Specialty Care Provider when the Member presents with any of the following:

1. An Acute Condition: For the duration of treatment of the acute condition;

2. A serious Chronic Health Condition: Up to twelve (12) months;

3. Pregnancy: For the duration of the pregnancy;

4. Terminal Illness: For the duration of the terminal illness, which may exceed twelve (12) months;

5. Care of a newborn child between birth and thirty-six (36) months: Up to twelve (12) months;

6. Surgery that is part of a documented course of treatment and has been recommended and documented by the out-of-network PCP, or Specialty Care Provider, to occur within one hundred-eighty (180) calendar days of the effective date of coverage for a new Member; or

7. ~~Resides~~Residing in an out-of-network nursing facility prior to enrollment ~~to~~in CalOptima, or ~~receives~~prior to receiving long term care benefits from CalOptima: Up to twelve (12) months.

D. CalOptima or a Health Network shall accept requests for Continuity of Care over the telephone, by facsimile, or by mail, according to the requestor's preference, from the following sources:

1. Member;

2. Authorized Representative of the Member; or

3. Provider.

E. Upon receiving a request for Continuity of Care, CalOptima's Customer Service Department shall initiate the following actions, as appropriate:

1. Assist the Member with requests to change the Member's Health Network and PCP, if the Member is requesting a PCP outside of his or her current Health Network and the PCP is contracted with another Health Network.

2. Establish the existence of an ongoing relationship with the requested provider.

   a. CalOptima shall utilize FFS data provided by DHCS, or utilization data from another Medi-Cal program administrator such as another Medi-Cal Managed Care Plan, if available.

   b. If CalOptima does not receive FFS data from DHCS, or if the data does not support a pre-existing relationship, and the Member has seen a provider in accordance with the criteria included in Section II.C.1. of this Policy, a provider shall submit a signed attestation to CalOptima that confirms the provider saw the Member for a medical visit within the ~~last twelve (12) months~~qualifying period stated in Section II.C.1., and include the last date ~~of the last visit~~upon which services were provided .

i. A self-attestation from a Member is insufficient to provide proof of a relationship with a provider.

c. The Continuity of Care process shall begin when CalOptima or the Health Network begin the process to determine if the Member has a pre-existing relationship with the provider.

d. If DHCS has notified CalOptima of a Provider suspension, termination, or decertification, CalOptima, or a Health Network, shall not approve the Continuity of Care request.

3. Refer the Member to his or her Health Network for a request to change the Member's PCP within the Member's Health Network. The Health Network shall process this request pursuant to this Policy.

4. Refer the Member to the CalOptima Behavioral Health Line for Behavioral Health Treatment (BHT) and outpatient mental health services.

5. Refer the case to CalOptima's Case Management Department for access to care issues.

F. For access to care issues, CalOptima's Case Management and Customer Service Departments shall work with one another and the Member's Health Network to outreach and connect the Member with his or her requested PCP, Specialty Care Provider, or other healthcare provider, in accordance with this Policy.

G. If the PCP ~~or,~~ Specialty Care Provider or other provider specified in this Policy is an out-of-network provider, CalOptima or the Health Network shall make a good faith effort to enter into a contract, letter of agreement (LOA), or single-case agreement, to establish a Continuity of Care relationship for the Member. Upon the execution of a Continuity of Care agreement, CalOptima or a Health Network shall establish a Member care plan with the ~~PCP or Specialty Care~~Existing Out-of-Network Provider.

H. CalOptima or a Health Network shall accommodate all requests they receive directly from Members who wish to be reassigned ~~to their FFS, or Covered California PCP, Specialty Care Provider, or other health care provider,~~Existing Out-of-Network Provider in accordance with this Policy.

I. CalOptima or a Health Network shall initiate the review process within five (5) working days after receiving the Continuity of Care request.

J. CalOptima or a Health Network shall complete the Continuity of Care request review process within the following timelines:

1. Thirty (30) calendar days from the date of request;

2. Fifteen (15) calendar days if the Member's medical condition requires more immediate attention, such as there are upcoming appointments, or other pressing care needs; or

3. Three (3) calendar days if there is risk of harm to the Member. For purposes of this policy, risk of harm means an imminent and serious threat to the health of the Member.

K. CalOptima or a Health Network shall notify the Member of the following, in writing, and within seven (7) calendar days of the completion of a Continuity of Care request:

1. The outcome of the request (approval or denial) sent to the Member by U.S. Mail;

2. The duration of the Continuity of Care arrangement, if approved;

   a. For any Continuity of Care response for which a provider is only willing to continue providing services for less than twelve (12) months, CalOptima or a Health Network shall allow the Member to have access to that provider for the shorter period of time.

3. The process that will occur to transition the Member at the end of the Continuity of Care period, if approved; and

4. The Member's right to choose a different provider from CalOptima's provider network.

5. If CalOptima and the ~~out~~Existing Out-of-~~network FFS provider~~Network Provider are unable to reach an agreement on the rate, or CalOptima has documented quality of care issues with the provider, CalOptima will offer the Member an in-network alternative. If the Member does not make a choice, the Member will be assigned to an in-network provider.

6. If the Member does not agree with the result of the Continuity of Care process, he or she retains the right to pursue a grievance ~~and/or appeal~~, in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint.

L. Thirty (30) calendar days prior to the end of the Continuity of Care period, CalOptima or a Health Network shall notify, in writing via U.S. Mail, the Member and the ~~out~~Existing Out-of-~~network PCP and/or Specialty Care Providers~~Network Provider of the transition ~~process~~of the Member's care to an in-network provider to ensure continuity of services through the transition to a new provider, except as provided in Section III.O.8.b.iv. for Members in the WCM program.

M. CalOptima or a Health Network shall accept and approve retroactive requests for Continuity of Care, subject to the provisions of this Policy and that:

1. Occurred after the Member's enrollment into CalOptima;

~~1.~~2. Have dates of service(s) that occur after ~~March 2, 2018~~December 29, 2014;

~~2.~~3. Have dates of service(s) within thirty (30) calendar days of the first date of service for which the ~~out~~Existing Out-of-~~network PCP, or Specialty Care~~Network Provider~~,~~ requested Continuity of Care retroactive reimbursement; and

~~3.~~4. Are submitted within thirty (30) calendar days of the first service for which retroactive Continuity of Care is requested.

N. The Continuity of Care request shall be considered complete when:

1. The Member is informed of the outcome of the request;

2. CalOptima or a Health Network and the provider are unable to agree to a rate;

3. CalOptima or a Health Network has documented quality of care issues with the provider; or

4. CalOptima or a Health Network has made a good faith effort to contact the provider and the provider is non-responsive for thirty (30) calendar days.

O. Other Continuity of Care Requirements

1. Former Covered California Enrollees

   a. CalOptima shall outreach to all former Covered California enrollees within fifteen (15) calendar days of their enrollment into CalOptima to inquire if the Member has upcoming appointments, or scheduled treatments. CalOptima shall assist the Member in making a Continuity of Care request at that time, as appropriate.

   b. CalOptima or a Health Network shall honor any active prior treatment authorizations for a former Covered California Member for up to sixty (60) calendar days, or until a new assessment is completed by a CalOptima contracted provider or a Health Network.

   c. CalOptima or a Health Network shall offer up to twelve (12) months of Continuity of Care with out-of-network PCP, or Specialty Care Providers, in accordance with Section II.C. of this Policy.

   d. CalOptima or a Health Network shall provide Continuity of Care for pregnant and post-partum Members and newborn children who transition from Covered CA with terminated~~,~~ or out-of-network~~,~~ providers in accordance with Health & Safety Code Section 1373.96 and Section III.C. of this Policy.

2. Seniors and Persons with Disabilities

   a. CalOptima or a Health Network shall honor, without request by the Member or the Member's out-of-network PCP or Specialty Care Providers, any active FFS Treatment Authorization Request (TAR) for a newly enrolled Seniors and Persons with Disabilities (SPDs) Member for sixty (60) calendar days from enrollment, or until a new assessment is completed by a CalOptima contracted provider to the extent FFS TAR data is available from DHCS.

      i. CalOptima or a Health Network shall provide continued access for newly enrolled SPD Members for up to twelve (12) months in accordance with ~~CalOptima Policy GG.1508: Authorization and Processing of Referrals~~the Policy.

   b. CalOptima shall further identify an SPD Member's health care needs by conducting a Health Risk Assessment in accordance with CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment.

~~3. Children Diagnosed with Autism Spectrum Disorder~~

3. Members Under Twenty-One Years of Age Receiving BHT Services

a. CalOptima shall provide continued access to an out-of-network BHT ~~providers~~Service Provider in accordance with Section II.C. of this Policy for up to twelve (12) months beginning on the date of the Member's enrollment in CalOptima, provided the Member has an existing relationship with the provider as defined in this Policy.

b. Retroactive requests for BHT service continuity of care reimbursement are limited to services provided after a Member's transition date into CalOptima, or the date of the Member's enrollment into CalOptima, if enrollment date occurred after the transition.

4. Children Receiving BHT Services at the ~~Regional Center of Orange County (~~RCOC~~)~~

a. For a Member receiving BHT services at RCOC Continuity of Care need not be requested and shall be automatic.

b. CalOptima ~~or a contracted BHT vendor~~ shall provide continued access to BHT services for a Member who transitions from RCOC to CalOptima for BHT ~~and shall utilize diagnosis, utilization, and assessment data provided by RCOC, or DHCS, to proactively identify current BHT providers. In the absence of data, CalOptima, or a contracted BHT vendor, shall contact the Member's parent(s), or guardian, to obtain the necessary information~~services.

c. ~~CalOptima or a contracted BHT vendor~~If a Member is receiving BHT services from a non-contracted BHT Service Provider, CalOptima shall utilize diagnosis, utilization information, and assessment data provided by RCOC, or DHCS, to proactively identify the current BHT Service Provider(s). If the data indicates that the Member has multiple BHT Service Providers, CalOptima shall contact the Member's parent(s) or guardian be telephone, letter, or other resource and make a good faith effort to obtain information that will assist in offering Continuity of Care. Once a preferred current provider has been identified, CalOptima shall proactively contact such BHT Service Provider(s) to begin the Continuity of Care process.

~~c.~~d. CalOptima shall make a good faith effort to enter into a Continuity of Care agreement with a Member's existing BHT Service Provider prior to the transition of the Member. CalOptima~~, or a contracted BHT vendor,~~ shall ensure Continuity of Care for a period of no more than twelve (12) months from the date of the Member's transition, if the ~~following~~ criteria as described in Section II.C. of the Policy are met~~:~~.

~~a) The Member has an existing relationship with the BHT Provider;~~

~~i. The BHT Provider will accept CalOptima, or Medi-Cal FFS rates, whichever is higher;~~

~~ii. The BHT Provider meets applicable professional standards and has no disqualifying quality of care issues;~~

~~iii. The BHT Provider is a State Plan approved provider, as defined in Health & Safety Code Section 1374.73; and~~

~~iv. Relevant documents, including but not limited to assessments and treatment plans are provided to CalOptima by the BHT Provider to facilitate Continuity of Care.~~

~~d.~~e. If CalOptima ~~or a contracted BHT vendor~~ and the Member's existing BHT ~~provider~~Service Provider(s) are unable to reach a Continuity of Care agreement, CalOptima~~, or a contracted BHT vendor,~~ shall contact the Member's parent(s), or guardian, to transition to an in-network BHT Provider through a warm hand off transfer to ensure there are no gaps in access to services. CalOptima~~, or a contracted BHT vendor,~~ shall ensure BHT services continue at the same level until a comprehensive diagnostic evaluation (CDE) and assessment, as appropriate, is conducted and a treatment plan established.

5. Pregnant and Post-Partum Members

   a. CalOptima or a Health Network shall provide continued access to out-of-network providers in accordance with Section II.C. of this Policy for up to twelve (12) months.

6. Nursing Facility Services

   a. CalOptima or a Health Network shall offer a Member residing in an out-of-network skilled nursing facility (SNF) when the Member transitioned into CalOptima the opportunity to return to the out-of-network SNF after a Medically Necessary absence, such as a hospital admission, for the duration of the Coordinated Care Initiative (CCI). CalOptima, or a Health Network, is not required to honor a request to return to an out-of-network SNF if the Member is discharged from the SNF into the community, or a lower level of care.

   b. CalOptima or a Health Network shall maintain Continuity of Care by recognizing any TARs made by DHCS for Nursing Facility (NF) services that were in effect when a Member enrolled into CalOptima to the extent DHCS provides FFS TAR data to CalOptima. CalOptima or a Health Network shall honor such TARs for twelve (12) months, or for the duration of the treatment authorization if the remaining authorized duration is less than twelve (12) months, following the enrollment of the Member into CalOptima.

   c. CalOptima or a Health Network shall not require a Member who is a resident of an NF prior to enrollment in CalOptima to change NFs during the duration of the CCI if the facility is licensed by the California Department of Public Health, meets acceptable quality standards, and the facility and CalOptima agree to Medi-Cal rates.

7. Non-Specialty Mental Health Services

   a. CalOptima shall provide continuity of care with an out-of-network Specialty Mental Health provider in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima. In this situation, the Continuity of Care requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medicaid State Plan, to provide outpatient, non-specialty mental health services, referred to in the State Plan as "Psychology."

   b. CalOptima shall allow, at the request of the Member, the Member's Specialty Mental Health provider, or the Member's Authorized Representative, up to twelve (12) months Continuity of Care with the out-of-network County Mental Health Plan provider in accordance with the requirements of this Policy.

c. After the Continuity of Care period ends, the Member must choose a mental health provider in CalOptima's network for non-specialty mental health services. If the Member later requires additional SMHS from the County Mental Health Plan to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to CalOptima for non-specialty mental health services, the twelve (12)-month Continuity of Care period may start over one (1) time. If the Member requires SMHS from the County Mental Health Plan subsequent to the Continuity of Care period, the Continuity of Care period does not start over when the Member returns to CalOptima or changes MCPs (i.e., the Member does not have the right to a new twelve (12) months of Continuity of Care).

8. Whole Child Model (WCM) Program

a. Effective January 1, 2019, CalOptima or a Health Network shall provide Continuity of Care for a Member eligible with the California Children's Services (CCS) Program and transitioned into the WCM program with the eligible Member's existing CCS provider for up to twelve (12) months in accordance with Section II.C.1. of this Policy.

b. For Members eligible with the CCS Program and transitioned into the WCM program, CalOptima or a Health Network shall also provide Continuity of Care for the following:

i. Specialized or Customized DME

a) If an eligible Member has an established relationship with a Specialized or Customized DME provider, CalOptima or a Health Network must provide access to that Specialized or Customized DME provider for up to twelve (12) months.

b) CalOptima or a Health Network shall pay the Specialized or Customized DME provider at rates that are at least equal to the applicable CCS FFS rates, unless the Specialized or Customized DME provider and CalOptima or Health Network enter into an agreement on an alternative payment methodology that is mutually agreed upon.

c) CalOptima or a Health Network may extend the Continuity of Care period beyond twelve (12) months for Specialized or Customized DME still under warranty and deemed Medically Necessary by the treating provider.

ii. Case Management

a) An eligible Member shall have the opportunity to request, within the first ninety (90) calendar days of the transition, to continue to receive case management from their existing CCS Public Health Nurse in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Program.

iii. Authorized Prescription Drugs

a) An eligible Member shall be permitted to continue use of any currently prescribed medication that is part of a prescribed therapy for the Member's CCS-Eligible Condition or conditions immediately prior to the date of transition of responsibility

for the Member's CCS services to CalOptima in accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process.

iv. Appealing Continuity of Care Limitations

a) CalOptima or a Health Network must provide an eligible Member with information regarding the WCM appeal process for Continuity of Care limitations, in writing, sixty (60) calendar days prior to the end of their authorized Continuity of Care period. The notice must explain the Member's right to petition CalOptima or a Health Network for an extension of the Continuity of Care period, the criteria used to evaluate the petition, and the appeals process if the MCP denies the petition. The appeals process notice must include the following information:

1) The eligible Member must first appeal a Continuity of Care decision with CalOptima in accordance with CalOptima Policy GG.1510: Appeals Process Regarding Care and Services; and

2) A eligible Member, the Member's family or designated caregiver of the eligible Member may appeal the Continuity of Care limitation to the Department of Health Care Services (DHCS) director or his or her designee after exhausting CalOptima's appeal process.

P. Health Networks shall report all requests and outcomes from former Medi-Cal FFS and former Covered California enrollees asking to remain with their PCPs, or Specialty Care Providers, to CalOptima's Health Network Relations Department in a format and at a frequency prescribed by CalOptima.

Q. CalOptima's Customer Service and Case Management Departments shall compile and maintain a log of Continuity of Care requests and outcomes made directly to CalOptima.

R. CalOptima's Customer Service, Health Network Relations, and Case Management Departments shall submit their Continuity of Care reports to CalOptima's Regulatory Affairs & Compliance Department. The Regulatory Affairs & Compliance Department shall submit the data to DHCS, in a manner and with a frequency prescribed by DHCS.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

~~A. California Health and Safety Code, §1374.73~~
~~B.~~A. ~~California Health and Safety Code, §1373.96~~
~~C.~~A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~D.~~B. CalOptima Policy GG.1401: Pharmacy Authorization Process
~~E.~~C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~F.~~D. CalOptima Policy HH.1102: CalOptima Member Complaint
~~G.~~E. CalOptima Policy GG.1301: Comprehensive Case Management
~~H.~~F. CalOptima Policy GG.1209: Population- Based Care: Disease Management
~~I.~~G. CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment

H. CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model
I. CalOptima Policy GG.1401: Pharmacy Authorization Process
J. CalOptima Policy GG.1510: Appeals Process Regarding Care and Services
K. California Health and Safety Code, §1374.73
L. California Health and Safety Code, §1373.96
M. California Welfare and Institutions Code §§ 14094.13(a)-(d), 14094.13(d)
~~J.~~N. Department of Health Care Services, All Plan Letter (APL) 15-004: Medi-Cal Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
~~K.~~O. Department of Health Care Services, All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care (Revised)
~~L.~~P. Department of Health Care Services, All Plan Letter (APL) ~~16-001 Medi-Cal Provider and Subcontract Suspensions, Terminations and Decertifications~~18-011: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVALS

A. 06/26/18: Department of Health Care Services
B. 01/31/18: Department of Health Care Services
C. 07/11/17: Department of Health Care Services
D. 08/23/16: Department of Health Care Services
E. 05/15/15: Department of Health Care Services

VII. BOARD ACTION

~~None to Date~~A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal
Revised	07/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal
Revised	09/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal
Revised	04/01/2016	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	07/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	11/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	10/04/2018	GG.1325	Continuity of Care for Members Transitioning into CalOptima Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Acute Condition	A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
Authorized Representative	~~Has the meaning given such term in section 164.502(g) of title 45, 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.
Behavioral Health Treatment (BHT)	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop and restore, to the maximum extent practicable, the functioning of an individual with ASD. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior.
Behavioral Health Treatment (BHT) ~~Providers~~Service Provider	~~Providers that are State Plan approved to render Behavioral Health Treatment services, including Qualified Autism Service Providers, Qualified Autism Service Professionals and Qualified Autism Service Paraprofessionals. For purposes of this policy, BHT providers are considered Specialty Care Providers.~~There are three (3) classifications: 1. Qualified Autism Services (QAS) Provider – A licensed practitioner or Board Certified Behavior Analyst (BCBA) 2. QAS Professional – A Behavior Management Consultant (BMC), BCBA, Behavior Management Assistant (BMA), or Behavior Analyst Associate (Board Certified Assistant Behavior Analyst) 3. QAS Paraprofessional – Minimum high school level with 40 hours of BHT training who is employed and supervised by a QAS provider.
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections41515.2 through 41518.9.
Chronic Health Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Existing Out-of-Network Provider	For purposes of this Policy, an out-of-network nursing facility, Primary Care Practitioner (PCP), Specialty Care Provider, Behavioral Health Treatment (BHT) Service Provider, Specialized or Customized Durable Medical Equipment (DME), or Specialty Mental Health provider.

Term	Definition
Health Risk Assessment	A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.[
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.
Medi-Cal Managed Care Plan	A health plan contracted with the Department of Health Care Services (DHCS) that provides Covered Services to Medi-Cal beneficiaries.
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.
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 Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W & I Code 14182(b)(11).
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Specialty Mental Health Services	Specialty Mental Health Services, which are the responsibility of the County Mental Health Plan, include the following: A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services. B. Psychiatric inpatient hospital services. C. Targeted Case Management. D. Psychiatrist services. E. Psychologist services. F. EPSDT supplemental Specialty Mental Health Services.

Term	Definition
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one year or less.
Treatment Authorization Request (TAR)	The form a provider uses to request authorization from Medi-Cal Fee-for-Service. Authorization is granted by a designated Medi-Cal consultant obtained through submission and approval of a TAR.

Policy #:	GG.1325
Title:	**Continuity of Care for Members Transitioning into CalOptima Services**
Department:	Medical Affairs
Section:	Case Management
CEO Approval:	Michael Schrader
Effective Date:	01/01/15
Review Date:	10/04/18
Revised Date:	10/04/18

I. PURPOSE

This policy establishes the Continuity of Care guidelines and the process to identify Members who have expedited care needs for newly enrolled Medi-Cal Members who transition into CalOptima or existing Members whose Covered Services are transitioned from Medi-Cal Fee-for-Service (FFS) to CalOptima.

II. POLICY

A. Effective July 1, 2017, CalOptima shall screen all new Members for the need for expedited services upon their enrollment into CalOptima as described in Section III.B. of this Policy.

B. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. Upon request from the Member, and in accordance with this Policy, CalOptima or a Health Network shall ensure Continuity of Care for a Medi-Cal beneficiary transitioning from Medi-Cal FFS, another Medi-Cal Managed Care Plan, or existing Members whose Covered Services are transitioned from Medi-Cal FFS to CalOptima, with his or her Existing Out-of-Network Provider for a period of no more than twelve (12) months, unless otherwise provided in Section III.C. of this Policy, if the following criteria are met:

1. A Member has an existing relationship with one (1) of the following. There is an existing relationship with:

   a. An out-of-network Primary Care Practitioner (PCP) or Specialty Care Provider if the Member has seen the out-of-network PCP, or Specialty Care Provider for a non-emergency visit at least once during the twelve (12) months prior to the date of enrollment in CalOptima;

   b. An out-of-network Behavioral Health Treatment (BHT) Service Provider if the Member has seen the out-of-network BHT Service Provider for a non-emergency visit at least once during the six (6) months prior to either the transition of services from the Regional Center of Orange County (RCOC) to CalOptima or the date of the Member's initial enrollment in CalOptima if the enrollment occurred on or after July 1, 2018;

   b. An out-of-network nursing facility if the Member has resided in the out-of-network nursing facility prior to enrollment in CalOptima, or prior to receiving long term care benefits from CalOptima; and

   c. A County Mental Health Plan Provider for non-specialty mental health services in instances where a Member's mental health condition has stabilized such that the Member no longer

qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima.

2. The Existing Out-of-Network Provider will accept CalOptima, or Medi-Cal FFS rates, whichever is higher;

3. The Existing Out-of-Network Provider meets applicable professional standards and has no disqualifying quality of care issues;

4. The Existing Out-of-Network Provider has not been terminated, suspended, or decertified from the Medi-Cal program by DHCS;

5. The Existing Out-of-Network Provider is a California State Plan-approved provider;

6. The Existing Out-of-Network Provider supplies CalOptima with all relevant assessment, diagnosis, and treatment information, for the purposes of determining Medical Necessity, as well as a current treatment plan as allowed under federal and state privacy laws and regulations; and

7. The Member, Authorized Representative of the Member, or the Existing Out-of-Network Provider requests Continuity of Care. For a Member residing in an out-of-network nursing facility prior to enrollment in CalOptima or receiving BHT services at RCOC, Continuity of Care is guaranteed and need not be requested.

D. CalOptima or a Health Network shall provide Continuity of Care for a Member as described in this Policy, except for the following types of providers:

1. Durable Medical Equipment (DME), excluding Specialized or Customized DME for Members eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model (WCM) program as described in Section III.O.8.b.i. of this Policy;

2. Transportation; and

3. Other ancillary services.

E. CalOptima and Health Networks are also required to comply with existing state law Continuity of Care obligations which may allow a Medi-Cal beneficiary a longer period of treatment by an out-of-network provider than would be required under DHCS All Plan Letter 18-008 (Revised).: Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care.

F. CalOptima or a Health Network shall not provide Continuity of Care for:

1. Services not covered by Medi-Cal; and

2. Services carved-out of CalOptima's contract with the Department of Health Care Services (DHCS).

G. If a Member changes Medi-Cal Managed Care Plans (MCP), the twelve (12) month Continuity of Care period may start over one (1) time. If a Member changes MCPs a second time (or more), the

Continuity of Care period does not start over, meaning that the Member does not have the right to a new twelve (12) months of Continuity of Care. If a beneficiary changes MCPs, this Continuity of Care Policy does not extend to providers that the beneficiary accessed through their previous MCP. If the Member returns to Medi-Cal FFS and later reenrolls in CalOptima, the Continuity of Care period does not start over, but may be completed only if the Member:

1. Returned to FFS for less than the twelve (12) month Continuity of Care period; and

2. Was eligible for and elected to receive Continuity of Care during the previous CalOptima enrollment period.

H. An approved Existing Out-of-Network Provider must work with CalOptima and its contracted network and cannot refer the Member to another out-of-network provider without prior authorization from CalOptima or a Health Network.

I. CalOptima shall inform Members of the Continuity of Care protections and how to initiate a Continuity of Care request in written Member materials, including but not limited to, the Member Handbook, available by request and on the CalOptima website at www.caloptima.org, and Member newsletter.

J. CalOptima or a Health Network shall provide training to call center staff who come into regular contact with Members about the Continuity of Care protections.

III. PROCEDURE

A. CalOptima shall include a health information form in each New Member Welcome Packet mailing with a postage paid envelope.

1. If the Member does not respond to the mailed health information form, CalOptima shall make two (2) call attempts within ninety (90) calendar days to remind the Member to complete the form.

B. CalOptima shall conduct an initial screening of all responses received within ninety (90) calendar days of the Members' effective date(s) of enrollment.

1. Additional outreach and care coordination activities may occur in accordance with CalOptima Policies GG.1301: Comprehensive Case Management Process and GG.1209: Population –Based Care: Disease Management.

2. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. Upon request from the Member, and in accordance with the requirements of this Policy, CalOptima or a Health Network shall provide the completion of Covered Services by an out-of-network nursing facility, PCP, or Specialty Care Provider when the Member presents with any of the following:

1. An Acute Condition: For the duration of treatment of the acute condition;

2. A serious Chronic Health Condition: Up to twelve (12) months;

3. Pregnancy: For the duration of the pregnancy;

4. Terminal Illness: For the duration of the terminal illness, which may exceed twelve (12) months;

5. Care of a newborn child between birth and thirty-six (36) months: Up to twelve (12) months;

6. Surgery that is part of a documented course of treatment and has been recommended and documented by the out-of-network PCP, or Specialty Care Provider, to occur within one hundred-eighty (180) calendar days of the effective date of coverage for a new Member; or

7. Residing in an out-of-network nursing facility prior to enrollment in CalOptima, or prior to receiving long term care benefits from CalOptima: Up to twelve (12) months.

D. CalOptima or a Health Network shall accept requests for Continuity of Care over the telephone, by facsimile, or by mail, according to the requestor's preference, from the following sources:

1. Member;

2. Authorized Representative of the Member; or

3. Provider.

E. Upon receiving a request for Continuity of Care, CalOptima's Customer Service Department shall initiate the following actions, as appropriate:

1. Assist the Member with requests to change the Member's Health Network and PCP, if the Member is requesting a PCP outside of his or her current Health Network and the PCP is contracted with another Health Network.

2. Establish the existence of an ongoing relationship with the requested provider.

a. CalOptima shall utilize FFS data provided by DHCS, or utilization data from another Medi-Cal program administrator such as another Medi-Cal Managed Care Plan, if available.

b. If CalOptima does not receive FFS data from DHCS, or if the data does not support a pre-existing relationship, and the Member has seen a provider in accordance with the criteria included in Section II.C.1. of this Policy, a provider shall submit a signed attestation to CalOptima that confirms the provider saw the Member for a medical visit within the qualifying period stated in Section II.C.1., and include the last date upon which services were provided .

i. A self-attestation from a Member is insufficient to provide proof of a relationship with a provider.

c. The Continuity of Care process shall begin when CalOptima or the Health Network begin the process to determine if the Member has a pre-existing relationship with the provider.

d. If DHCS has notified CalOptima of a Provider suspension, termination, or decertification, CalOptima, or a Health Network, shall not approve the Continuity of Care request.

3. Refer the Member to his or her Health Network for a request to change the Member's PCP within the Member's Health Network. The Health Network shall process this request pursuant to this Policy.

4. Refer the Member to the CalOptima Behavioral Health Line for Behavioral Health Treatment (BHT) and outpatient mental health services.

5. Refer the case to CalOptima's Case Management Department for access to care issues.

F. For access to care issues, CalOptima's Case Management and Customer Service Departments shall work with one another and the Member's Health Network to outreach and connect the Member with his or her requested PCP, Specialty Care Provider, or other healthcare provider, in accordance with this Policy.

G. If the PCP, Specialty Care Provider or other provider specified in this Policy is an out-of-network provider, CalOptima or the Health Network shall make a good faith effort to enter into a contract, letter of agreement (LOA), or single-case agreement, to establish a Continuity of Care relationship for the Member. Upon the execution of a Continuity of Care agreement, CalOptima or a Health Network shall establish a Member care plan with the Existing Out-of-Network Provider.

H. CalOptima or a Health Network shall accommodate all requests they receive directly from Members who wish to be reassigned Existing Out-of-Network Provider in accordance with this Policy.

I. CalOptima or a Health Network shall initiate the review process within five (5) working days after receiving the Continuity of Care request.

J. CalOptima or a Health Network shall complete the Continuity of Care request review process within the following timelines:

1. Thirty (30) calendar days from the date of request;

2. Fifteen (15) calendar days if the Member's medical condition requires more immediate attention, such as there are upcoming appointments, or other pressing care needs; or

3. Three (3) calendar days if there is risk of harm to the Member. For purposes of this policy, risk of harm means an imminent and serious threat to the health of the Member.

K. CalOptima or a Health Network shall notify the Member of the following, in writing, and within seven (7) calendar days of the completion of a Continuity of Care request:

1. The outcome of the request (approval or denial) sent to the Member by U.S. Mail;

2. The duration of the Continuity of Care arrangement, if approved;

a. For any Continuity of Care response for which a provider is only willing to continue providing services for less than twelve (12) months, CalOptima or a Health Network shall allow the Member to have access to that provider for the shorter period of time.

3. The process that will occur to transition the Member at the end of the Continuity of Care period, if approved; and

4. The Member's right to choose a different provider from CalOptima's provider network.

5. If CalOptima and the Existing Out-of-Network Provider are unable to reach an agreement on the rate, or CalOptima has documented quality of care issues with the provider, CalOptima will offer the Member an in-network alternative. If the Member does not make a choice, the Member will be assigned to an in-network provider.

6. If the Member does not agree with the result of the Continuity of Care process, he or she retains the right to pursue a grievance, in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint.

L. Thirty (30) calendar days prior to the end of the Continuity of Care period, CalOptima or a Health Network shall notify, in writing via U.S. Mail, the Member and the Existing Out-of-Network Provider of the transition of the Member's care to an in-network provider to ensure continuity of services through the transition to a new provider, except as provided in Section III.O.8.b.iv. for Members in the WCM program.

M. CalOptima or a Health Network shall accept and approve retroactive requests for Continuity of Care, subject to the provisions of this Policy and that:

1. Occurred after the Member's enrollment into CalOptima;

2. Have dates of service(s) that occur after December 29, 2014;

3. Have dates of service(s) within thirty (30) calendar days of the first date of service for which the Existing Out-of-Network Provider requested Continuity of Care retroactive reimbursement; and

4. Are submitted within thirty (30) calendar days of the first service for which retroactive Continuity of Care is requested.

N. The Continuity of Care request shall be considered complete when:

1. The Member is informed of the outcome of the request;

2. CalOptima or a Health Network and the provider are unable to agree to a rate;

3. CalOptima or a Health Network has documented quality of care issues with the provider; or

4. CalOptima or a Health Network has made a good faith effort to contact the provider and the provider is non-responsive for thirty (30) calendar days.

O. Other Continuity of Care Requirements

1. Former Covered California Enrollees

a. CalOptima shall outreach to all former Covered California enrollees within fifteen (15) calendar days of their enrollment into CalOptima to inquire if the Member has upcoming

appointments, or scheduled treatments. CalOptima shall assist the Member in making a Continuity of Care request at that time, as appropriate.

b. CalOptima or a Health Network shall honor any active prior treatment authorizations for a former Covered California Member for up to sixty (60) calendar days, or until a new assessment is completed by a CalOptima contracted provider or a Health Network.

c. CalOptima or a Health Network shall offer up to twelve (12) months of Continuity of Care with out-of-network PCP, or Specialty Care Providers, in accordance with Section II.C. of this Policy.

d. CalOptima or a Health Network shall provide Continuity of Care for pregnant and post-partum Members and newborn children who transition from Covered CA with terminated or out-of-network providers in accordance with Health & Safety Code Section 1373.96 and Section III.C. of this Policy.

2. Seniors and Persons with Disabilities

a. CalOptima or a Health Network shall honor, without request by the Member or the Member's out-of-network PCP or Specialty Care Providers, any active FFS Treatment Authorization Request (TAR) for a newly enrolled Seniors and Persons with Disabilities (SPDs) Member for sixty (60) calendar days from enrollment, or until a new assessment is completed by a CalOptima contracted provider to the extent FFS TAR data is available from DHCS.

i. CalOptima or a Health Network shall provide continued access for newly enrolled SPD Members for up to twelve (12) months in accordance with the Policy.

b. CalOptima shall further identify an SPD Member's health care needs by conducting a Health Risk Assessment in accordance with CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment.

3. Members Under Twenty-One Years of Age Receiving BHT Services

a. CalOptima shall provide continued access to an out-of-network BHT Service Provider in accordance with Section II.C. of this Policy for up to twelve (12) months beginning on the date of the Member's enrollment in CalOptima, provided the Member has an existing relationship with the provider as defined in this Policy.

b. Retroactive requests for BHT service continuity of care reimbursement are limited to services provided after a Member's transition date into CalOptima, or the date of the Member's enrollment into CalOptima, if enrollment date occurred after the transition.

4. Children Receiving BHT Services at the RCOC

a. For a Member receiving BHT services at RCOC Continuity of Care need not be requested and shall be automatic.

b. CalOptima shall provide continued access to BHT services for a Member who transitions from RCOC to CalOptima for BHT services.

c. If a Member is receiving BHT services from a non-contracted BHT Service Provider, CalOptima shall utilize diagnosis, utilization information, and assessment data provided by RCOC, or DHCS, to proactively identify the current BHT Service Provider(s). If the data indicates that the Member has multiple BHT Service Providers, CalOptima shall contact the Member's parent(s) or guardian be telephone, letter, or other resource and make a good faith effort to obtain information that will assist in offering Continuity of Care. Once a preferred current provider has been identified, CalOptima shall proactively contact such BHT Service Provider(s) to begin the Continuity of Care process.

d. CalOptima shall make a good faith effort to enter into a Continuity of Care agreement with a Member's existing BHT Service Provider prior to the transition of the Member. CalOptima shall ensure Continuity of Care for a period of no more than twelve (12) months from the date of the Member's transition, if the criteria as described in Section II.C. of the Policy are met.

e. If CalOptima and the Member's existing BHT Service Provider(s) are unable to reach a Continuity of Care agreement, CalOptima shall contact the Member's parent(s), or guardian, to transition to an in-network BHT Provider through a warm hand off transfer to ensure there are no gaps in access to services. CalOptima shall ensure BHT services continue at the same level until a comprehensive diagnostic evaluation (CDE) and assessment, as appropriate, is conducted and a treatment plan established.

5. Pregnant and Post-Partum Members

a. CalOptima or a Health Network shall provide continued access to out-of-network providers in accordance with Section II.C. of this Policy for up to twelve (12) months.

6. Nursing Facility Services

a. CalOptima or a Health Network shall offer a Member residing in an out-of-network skilled nursing facility (SNF) when the Member transitioned into CalOptima the opportunity to return to the out-of-network SNF after a Medically Necessary absence, such as a hospital admission, for the duration of the Coordinated Care Initiative (CCI). CalOptima, or a Health Network, is not required to honor a request to return to an out-of-network SNF if the Member is discharged from the SNF into the community, or a lower level of care.

b. CalOptima or a Health Network shall maintain Continuity of Care by recognizing any TARs made by DHCS for Nursing Facility (NF) services that were in effect when a Member enrolled into CalOptima to the extent DHCS provides FFS TAR data to CalOptima. CalOptima or a Health Network shall honor such TARs for twelve (12) months, or for the duration of the treatment authorization if the remaining authorized duration is less than twelve (12) months, following the enrollment of the Member into CalOptima.

c. CalOptima or a Health Network shall not require a Member who is a resident of an NF prior to enrollment in CalOptima to change NFs during the duration of the CCI if the facility is licensed by the California Department of Public Health, meets acceptable quality standards, and the facility and CalOptima agree to Medi-Cal rates.

7. Non-Specialty Mental Health Services

a. CalOptima shall provide continuity of care with an out-of-network Specialty Mental Health provider in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima. In this situation, the Continuity of Care requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medicaid State Plan, to provide outpatient, non-specialty mental health services, referred to in the State Plan as "Psychology."

b. CalOptima shall allow, at the request of the Member, the Member's Specialty Mental Health provider, or the Member's Authorized Representative, up to twelve (12) months Continuity of Care with the out-of-network County Mental Health Plan provider in accordance with the requirements of this Policy.

c. After the Continuity of Care period ends, the Member must choose a mental health provider in CalOptima's network for non-specialty mental health services. If the Member later requires additional SMHS from the County Mental Health Plan to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to CalOptima for non-specialty mental health services, the twelve (12)-month Continuity of Care period may start over one (1) time. If the Member requires SMHS from the County Mental Health Plan subsequent to the Continuity of Care period, the Continuity of Care period does not start over when the Member returns to CalOptima or changes MCPs (i.e., the Member does not have the right to a new twelve (12) months of Continuity of Care).

8. Whole Child Model (WCM) Program

a. Effective January 1, 2019, CalOptima or a Health Network shall provide Continuity of Care for a Member eligible with the California Children's Services (CCS) Program and transitioned into the WCM program with the eligible Member's existing CCS provider for up to twelve (12) months in accordance with Section II.C.1. of this Policy.

b. For Members eligible with the CCS Program and transitioned into the WCM program, CalOptima or a Health Network shall also provide Continuity of Care for the following:

i. Specialized or Customized DME

a) If an eligible Member has an established relationship with a Specialized or Customized DME provider, CalOptima or a Health Network must provide access to that Specialized or Customized DME provider for up to twelve (12) months.

b) CalOptima or a Health Network shall pay the Specialized or Customized DME provider at rates that are at least equal to the applicable CCS FFS rates, unless the Specialized or Customized DME provider and CalOptima or Health Network enter into an agreement on an alternative payment methodology that is mutually agreed upon.

c) CalOptima or a Health Network may extend the Continuity of Care period beyond twelve (12) months for Specialized or Customized DME still under warranty and deemed Medically Necessary by the treating provider.

ii. Case Management

a) An eligible Member shall have the opportunity to request, within the first ninety (90) calendar days of the transition, to continue to receive case management from their existing CCS Public Health Nurse in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Program.

iii. Authorized Prescription Drugs

a) An eligible Member shall be permitted to continue use of any currently prescribed medication that is part of a prescribed therapy for the Member's CCS-Eligible Condition or conditions immediately prior to the date of transition of responsibility for the Member's CCS services to CalOptima in accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process.

iv. Appealing Continuity of Care Limitations

a) CalOptima or a Health Network must provide an eligible Member with information regarding the WCM appeal process for Continuity of Care limitations, in writing, sixty (60) calendar days prior to the end of their authorized Continuity of Care period. The notice must explain the Member's right to petition CalOptima or a Health Network for an extension of the Continuity of Care period, the criteria used to evaluate the petition, and the appeals process if the MCP denies the petition. The appeals process notice must include the following information:

1) The eligible Member must first appeal a Continuity of Care decision with CalOptima in accordance with CalOptima Policy GG.1510: Appeals Process Regarding Care and Services; and

2) A eligible Member, the Member's family or designated caregiver of the eligible Member may appeal the Continuity of Care limitation to the Department of Health Care Services (DHCS) director or his or her designee after exhausting CalOptima's appeal process.

P. Health Networks shall report all requests and outcomes from former Medi-Cal FFS and former Covered California enrollees asking to remain with their PCPs, or Specialty Care Providers, to CalOptima's Health Network Relations Department in a format and at a frequency prescribed by CalOptima.

Q. CalOptima's Customer Service and Case Management Departments shall compile and maintain a log of Continuity of Care requests and outcomes made directly to CalOptima.

R. CalOptima's Customer Service, Health Network Relations, and Case Management Departments shall submit their Continuity of Care reports to CalOptima's Regulatory Affairs & Compliance Department. The Regulatory Affairs & Compliance Department shall submit the data to DHCS, in a manner and with a frequency prescribed by DHCS.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1401: Pharmacy Authorization Process
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy HH.1102: CalOptima Member Complaint
E. CalOptima Policy GG.1301: Comprehensive Case Management
F. CalOptima Policy GG.1209: Population- Based Care: Disease Management
G. CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment
H. CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model
I. CalOptima Policy GG.1401: Pharmacy Authorization Process
J. CalOptima Policy GG.1510: Appeals Process Regarding Care and Services
K. California Health and Safety Code, §1374.73
L. California Health and Safety Code, §1373.96
M. California Welfare and Institutions Code §§ 14094.13(a)-(d), 14094.13(d)
N. Department of Health Care Services, All Plan Letter (APL) 15-004: Medi-Cal Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
O. Department of Health Care Services, All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care (Revised)
P. Department of Health Care Services, All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVALS

A. 06/26/18: Department of Health Care Services
B. 01/31/18: Department of Health Care Services
C. 07/11/17: Department of Health Care Services
D. 08/23/16: Department of Health Care Services
E. 05/15/15: Department of Health Care Services

VII. BOARD ACTION

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	07/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal
Revised	09/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal
Revised	04/01/2016	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal
Revised	07/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	11/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	10/04/2018	GG.1325	Continuity of Care for Members Transitioning into CalOptima Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Acute Condition	A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
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.
Behavioral Health Treatment (BHT)	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop and restore, to the maximum extent practicable, the functioning of an individual with ASD. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior.
Behavioral Health Treatment (BHT) Service Provider	There are three (3) classifications: 1. Qualified Autism Services (QAS) Provider – A licensed practitioner or Board Certified Behavior Analyst (BCBA) 2. QAS Professional – A Behavior Management Consultant (BMC), BCBA, Behavior Management Assistant (BMA), or Behavior Analyst Associate (Board Certified Assistant Behavior Analyst) 3. QAS Paraprofessional – Minimum high school level with 40 hours of BHT training who is employed and supervised by a QAS provider.
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections41515.2 through 41518.9.
Chronic Health Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Existing Out-of-Network Provider	For purposes of this Policy, an out-of-network nursing facility, Primary Care Practitioner (PCP), Specialty Care Provider, Behavioral Health Treatment (BHT) Service Provider, Specialized or Customized Durable Medical Equipment (DME), or Specialty Mental Health provider.
Health Risk Assessment	A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.[1]

Term	Definition
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medi-Cal Managed Care Plan	A health plan contracted with the Department of Health Care Services (DHCS) that provides Covered Services to Medi-Cal beneficiaries.
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.
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 Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W & I Code 14182(b)(11).
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Specialty Mental Health Services	Specialty Mental Health Services, which are the responsibility of the County Mental Health Plan, include the following: A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services. B. Psychiatric inpatient hospital services. C. Targeted Case Management. D. Psychiatrist services. E. Psychologist services. F. EPSDT supplemental Specialty Mental Health Services.

Term	Definition
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one year or less.
Treatment Authorization Request (TAR)	The form a provider uses to request authorization from Medi-Cal Fee-for-Service. Authorization is granted by a designated Medi-Cal consultant obtained through submission and approval of a TAR.

1

Policy #: GG.1330PP
Title: **Case Management - California Children's Services Program/Whole Child Model**
Department: Medical Affairs
Section: Case Management

CEO Approval: Michael Schrader _____

Effective Date: 01/01/19
Last Review Date: Not Applicable
Last Revised Date: Not Applicable

I. PURPOSE

This policy defines the guidelines for the provision of Case Management by CalOptima or a Health Network to CalOptima Members eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model (WCM) program, newly CCS-eligible Members or new CCS Members enrolling in CalOptima.

II. POLICY

A. Effective January 1, 2019, CalOptima or a Health Network shall assume responsibility for authorization and payment of CCS-eligible medical services, including authorization activities, claims processing and payment, case management, and quality oversight.

1. CalOptima and its Health Networks shall ensure the provision of case management and care coordination for CCS by staff with knowledge or adequate training on the CCS program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions.

B. CalOptima or a Health Network shall identify and refer Members with potential CCS-Eligible Conditions to the local CCS Program for CCS medical eligibility determination in accordance with CalOptima Policy GG.1101: California Children's Services.

C. CalOptima shall identify the health risk of each CCS-eligible Member using a Department of Health Care Services (DHCS)-approved proprietary pediatric risk stratification algorithm within forty-five (45) calendar days of the eligibility with the CCS Program or transition into the WCM program.

D. Based on the results of the risk stratification, CalOptima shall assess each CCS-eligible Member's risk level and needs to ensure the appropriate provision of case management, care coordination, provider referral, and/or service authorization from a CCS-paneled provider through the administration of a DHCS-approved Health Needs Assessment (HNA), or risk assessment, as follows:

1. High-risk: Within ninety (90) calendar days; and

2. Low-risk: Within one hundred twenty (120) calendar days.

3. CalOptima shall reassess Members as follows:

    a. Annually, at a Member's CCS eligibility redetermination; or

    b. Upon signification change to a Member's health condition.

4. The HNA shall address, at a minimum, the following:

    a. General health status and recent health care utilization;

    b. Health history;

    c. Specialty provider referral needs;

    d. Prescription medication utilization;

    e. Specialized or customized durable medical equipment (DME) needs;

    f. Need for specialized therapies;

    g. Limitations of activities of daily living (ADLs) or daily functioning;

    h. Demographics and social history; and

    i. Age-specific questions.

E. CalOptima or a Health Network shall use the HNA to develop an Individual Care Plan (ICP) individualized to meet Member's medical (including specialty care and behavioral health needs), functional, psychosocial, social support and access to care needs, for all members assigned a care management level of care coordination or complex care management.

F. CalOptima or a Health Network shall proactively coordinate services for a CCS-eligible Member reaching twenty-one (21) years of age, including:

1. Identification of primary care and specialty care providers appropriate to the Member's CCS-Eligible condition; and

2. Assistance with transition planning to allow for purposeful, planned preparation of Members, families, and caregivers for transfer of a Member from pediatric to adult medical or health care services prior to age twenty-one (21).

G. CalOptima or a Health Network shall provide care coordination to CCS-eligible Members who are in need of an adult provider when a treating CCS-paneled provider determines his or her services are no longer beneficial or appropriate to the treatment of the CCS-eligible Member. The timing of the transition should be individualized to take into consideration the Member's medical condition and the established need for care with adult providers.

H. Members eligible with CCS Program and transitioned into the WCM program may submit a request to continue receiving case management and care coordination service from his or her

existing public health nurse. A Member shall submit the request to CalOptima within ninety (90) calendar days of his or her transition date.

I. CalOptima shall convene a quarterly meeting between CalOptima and the local CCS Program to assist with overall coordination by updating policies, procedures, and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding and other WCM related matters.

J. CalOptima shall ensure that the HNA is provided in a linguistically and culturally appropriate manner and will offer an in-person assessment.

K. For Members eligible with CCS Program and transitioned into the WCM program, CalOptima and a Health Network shall identify and track CCS-eligible Members for the duration of their participation in the WCM program, and for those who continue to be enrolled in CalOptima, for at least three (3) years after they age-out of the WCM program.

L. CalOptima, a Health Network, or a practitioner shall identify Members who may have a CCS-Eligible Condition in accordance with CalOptima Policies GG.1101: California Children's Services and GG.1116: Pediatric Preventive Services.

M. CalOptima and its Health Networks shall provide appropriate preventive, mental health, developmental, and specialty EPSDT medical services under the scope of the CalOptima program to eligible children under age twenty-one (21) years in accordance with GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

N. CalOptima or a Health Network shall ensure the provision of the Maintenance and Transportation benefit for eligible Members and a Member's family seeking transportation to a medical service related to the Member's CCS-Eligible Condition in accordance with CalOptima Policy GG.1547: Maintenance and Transportation.

III. PROCEDURE

A. Pediatric Risk Stratification

1. The pediatric risk stratification algorithm shall incorporate Member-specific data that signifies each CCS-eligible Member's clinical history and specific utilization data to assess the health risk, high or low, of a Member to include review of:

   a. Medical utilization data;

   b. Medical claims and encounter data;

   c. Existing assessment or survey data;

   d. Pharmacy data;

   e. Data provided by the local CCS Program and DHCS; and

f. Telephonic or in-person communications, if available at the time of the risk stratification.

2. For Members for which medical utilization data, claims processing data, or other assessments or survey information is not available, CalOptima shall automatically categorize such Member as high-risk until CalOptima is able to gather further assessment data to make an additional risk determination.

B. Health Needs Assessment

1. Upon enrollment in CCS or transition to WCM, CalOptima shall perform outreach to a CCS-eligible Member to complete the HNA telephonically or in-person as follows:

a. High Risk Members

i. CalOptima shall make three (3) attempts to reach the Member/Member's family by telephone within ninety (90) calendar days. CalOptima shall offer to assist the Member with completion of the HNA by telephone or in-person.

ii. If CalOptima is not able to reach the Member after three (3) attempts, CalOptima shall mail a letter to the Member's address, requesting the Member telephone CalOptima to complete the HNA.

iii. CalOptima shall establish an Individual Care Plan (ICP) for high risk Members based on the results of the risk stratification and HNA, within ninety (90) calendar days of the completion of the HNA or other assessment by telephone or in-person communication and as described in Section III.D. of this Policy.

iv. For Members eligible with CCS Program and transitioned into the WCM program, CalOptima shall complete risk stratification and telephonic and/or in person communication within one (1) year, including the ICP.

b. Low Risk Members

i. CalOptima shall make three (3) attempts to reach the Member/Member's family by telephone within one hundred twenty (120) calendar days. CalOptima shall offer to assist the Member with completion of the HNA by telephone or in-person.

ii. If CalOptima is not able to reach the Member after three (3) attempts, CalOptima shall mail a letter to the Member's address, requesting the Member telephone CalOptima to complete the HNA.

iii. For Members eligible with CCS Program and transitioned into the WCM program, CalOptima shall complete risk stratification and telephonic and/or in person communication within one (1) year.

2. CalOptima shall offer an in-person HNA to a CCS-eligible Member administered by a CalOptima Registered Nurse or Personal Care Coordinator (PCC) when a Member's

health condition precludes the administration of an HNA via telephone during the HNA collection time period (based on risk level), including but not limited to, inpatient hospitalization.

3. If a Member fails to complete the HNA after the third outreach attempt, CalOptima shall close the Member's HNA file in the electronic database.

4. CalOptima shall offer reassessment annually, either telephonically or in-person, to all CCS-eligible Members no later than the anniversary date of their most recent HNA or the month of their eligibility date, if no HNA has been collected.

C. Care Management and Care Coordination

1. A CalOptima Registered Nurse shall review and evaluate the pediatric risk stratification results and the responses to the HNA to assign one (1) of the following care management levels to a CCS-eligible Member:

   a. Complex care management (high risk);

   b. Care coordination care management (high risk); or

   c. Basic care management.

2. Care Management

   a. CalOptima or a Health Network will assign a Personal Care Coordinator (PCC) to each CCS-eligible Member. The PCC shall serve as the Member's assigned point of contact with CalOptima or a Health Network. The PCC shall:

      i. Perform initial and periodic outreach to assist the Member with care coordination;

      ii. Provide information, education and support continuously, as appropriate; and

      iii. Assist the Member and the Member's family in understanding the CCS-eligible Member's health, other available services, and how to access those services.

   b. PCCs shall be supported by a CalOptima or Health Network Registered Nurse for clinical considerations.

   c. CalOptima or a Health Network may transition a Member to a higher or lower level of care management as needed, due to a change in the Member's condition or as requested by the Member.

3. For those Members assigned a care management level of care coordination care management or complex care management, CalOptima or a Health Network shall assign a licensed care manager, in addition to the PCC. An ICP shall be developed within ninety (90) calendar days of a completed HNA and in accordance with Section III.D. of this

Policy. The ICP shall be shared with the Member and/or Member's family, PCP, and Interdisciplinary Care Team (ICT).

4. The Care Management process shall also address:

   a. Access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an Interdisciplinary Care Team (ICT) is, and what the community resources are;

   b. A primary or specialty care physician who is the primary clinician for the CCS-eligible Member and who provides core clinical management functions;

   c. Care management and care coordination for the CCS-eligible Member across the health care system, including transitions among levels of care and ICTs; and

   d. Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of CalOptima;

5. CalOptima or a Health Network shall ensure ongoing care coordination in accordance with CalOptima Policy GG.1301: Comprehensive Case Management Process.

D. Individual Care Plan (ICP)

1. CalOptima or a Health Network shall develop an ICP for a high-risk Member within ninety (90) calendar days of the completion of the HNA or other assessment, by telephone or in-person communication. CalOptima shall develop the ICP in collaboration with the Member, as appropriate, the Member's family, or caregiver and ICT.

2. The ICP shall incorporate the CCS-eligible Member's goals and preferences and provide measurable objectives and timeframes for completion to meet the needs for:

   a. Medical services (primary and specialty services);

   b. Mild to moderate or county specialty mental health services;

   c. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);

   d. County substance use disorder (SUD) or Drug Medi-Cal services;

   e. Home health services;

   f. Regional center services; and

   g. Other Medically Necessary services provided by CalOptima or a Health Network, including when necessary, out of network providers.

3. CalOptima or a Health Network shall reevaluate and update each CCS-eligible Member's ICP at least annually or upon a significant change to the Member's condition.

E. Continuity of Care - Case Management

1. Members eligible with CCS Program and transitioned into the WCM program shall have the opportunity to request, within the first ninety (90) calendar days of the transition, to continue to receive case management from their existing CCS Public Health Nurse (PHN).

2. Upon receipt of a request for continuity of case management services, CalOptima shall communicate this request to the local CCS Program within five (5) business days.

   a. If the Member's PHN is available to continue case management, CalOptima or a Health Network shall coordinate care with the CCS PHN.

   b. If the Member's PHN is not available, CalOptima or a Health Network shall ensure that case management services are provided by a case manager who has received adequate training on the county CCS program and who has clinical experience with the CCS population or pediatric patients with complex medical conditions.

F. Age-Out Transition and Planning

1. CalOptima or a Health Network shall proactively coordinate services for a CCS-eligible Member reaching twenty-one (21) years of age as follows:

   a. Age 14:

      i. Identify CCS eligible Members who will require long-term health care transition planning; and

      ii. Notify, via mail, the Member, the Member's family, and PCP, of the transition process.

   b. Age 16:

      i. Identify CCS-eligible Members who will require long-term health care transition planning who were not identified or known at age 14;

      ii. Notify, via mail, the PCPs of newly identified Members about the transition planning process;

      iii. Notify, via mail, the Member and the Member's family of the need to formally institute transition planning;

      iv. Notify the PCP of the need to schedule an adolescent transition health care conference; and

v. Request information from special care centers, as appropriate, regarding steps the center(s) has taken to institute the transition planning process, including identification or primary and specialty care providers appropriate to the Member's CCS-Eligible Condition who will provide care after the Member's 21st birthday, the need for DME, and the Member's PCP.

c. Age 17:

i. Send Adult Services Declaration and Notice of Privacy Practices with acknowledgement receipt to those CCS-eligible Members identified as needing transition services.

d. Age 18:

i. Identify CCS-eligible Members who will require long term health care transition planning who were not identified or known at age 16;

ii. Notify, via mail, the PCPs of newly identified Members about the transition planning process;

iii. Notify, via mail, the Member and the Member's family of the need to prepare or update transition planning;

iv. If not received, resend Notice of Privacy Practices with acknowledgement of receipt via mail;

v. Request updated information from special care centers regarding steps the center (s) has taken to institute the transition planning process, including identification or primary and specialty care providers appropriate to the Member's CCS-Eligible Condition who will provide care after the Member's 21st birthday, the need for DME, and the Member's PCP.

e. Age 20:

i. Identify CCS-eligible Members who will require long term health care transition planning who were not identified or known to the program at age 18;

ii. Notify, via mail, the PCPs of newly identified Members about the transition planning process;

iii. Notify the Member and the Member's family of the need to prepare or update transition planning, or update Adolescent Transition Health Care Plan to identify any unmet needs and modify, as necessary;

iv. Send a letter to the Member's CCS PCP to determine if he or she will continue to provide care after the Member's 21st birthday and name of the identified adult provider if the pediatric provider will not continue care. If necessary, request a referral to adult provider if one is required and has not been identified;

v. Send a letter to the Member and the Member's family requesting transition planning meeting or teleconference;

vi. Evaluate the Member for additional care coordination needs; and

vii. Send an exit interview survey to the Member and the Member's family.

f. Age 20 and 8 months:

i. A CCS-eligible Member who is enrolled in CHOC Health Alliance shall select another Health Network prior to his or her twenty-first (21st) birthday in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network (CCN) Selection Process; and

ii. CalOptima will assist Members who need to change his or her Health Network with selecting a new Health Network and with coordinating care through the transition.

F. Moving Out-of-Area

1. Upon notification that a CCS-eligible Member has moved to another county, CalOptima shall provide the local CCS Program with the following:

a. A copy of the PCP version of the most recent ICP;

b. Clinical and other relevant data;

c. Any open authorizations; and

d. The most recent HNA.

G. Case Management Oversight of Health Network ICPs

1. CalOptima Registered Nurses shall review the data collected from each HNA and shall:

a. Evaluate completion and accuracy of information provided;

b. Evaluate clinical data;

c. Assign a provisional care management level; and

d. Prepare a provisional initial care plan (iCP), as appropriate

2. A CalOptima Registered Nurse shall upload the iCP and HNA via secure FTP site to the CCS-eligible Member's assigned Health Network for completion of the ICP, as appropriate.

3. The Health Network shall retrieve the iCP and HNA.

4. The licensed care manager at the Health Network shall be responsible for the care management of the Member as described in Section III.C. of this Policy.

5. Upon completion of the ICP, the Health Network shall upload the completed ICP and supporting records to the secure FTP site.

6. On a daily basis, CalOptima shall retrieve the completed ICPs and records from the secure FTP site.

7. CalOptima Registered Nurses shall review the completed ICPs and records for completeness, accuracy and compliance with the requirements of this Policy.

8. CalOptima Registered Nurses shall document their review of each returned record in the CalOptima medical management system.

9. On a daily basis, CalOptima shall communicate any deficiencies to the Health Network.

10. On a monthly basis, CalOptima shall provide feedback regarding the scoring of the ICP bundles to the Health Network.

IV. ATTACHMENTS

A. Health Needs Assessment

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. CalOptima Policy DD.2008: Health Network and CalOptima Community Network (CCN) Selection Process
D. CalOptima Policy GG.1101: California Children's Services
E. CalOptima Policy GG.1116: Pediatric Preventive Services
F. CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
G. CalOptima Policy GG.1301: Comprehensive Case Management Process.
H. CalOptima Policy GG.1508: Authorization and Processing of Referrals
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-011: California Children's Service Whole Child Model Program
J. Welfare and Institutions Code §§ 14094.7(d)(4)(C), 14094.11(b)(1)-(6), 14094.11(c), 14094.12(j), 14094.13(e)-(g)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2019	GG.1330PP	Case Management - California Children's Services Program/Whole Child Model	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services Eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
Case Management	A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
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 Needs Assessment (HNA)	The assessment CalOptima uses as a health risk assessment for CCS-eligible Members.
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 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.
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.
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.

Readability Grade Level: Gunning Fog 6.2, SMOG 4.7, 7/6/2018AS (Eliminated the chart, answer choices for question #s 1, 9-11 and all the answer lines)
Reviewed by VC 7-17-18; Reviewed by MKC 7-17-18; e-ticket# SVC-18-004276; Readability Grade Level: Gunning Fog 6.9, SMOG 5.6 on 7-17-18 by MKC (Eliminated the chart, answer choices for question #s 1, 9-11 and all the answer lines)
7/23/18 Readability Updated to Gunning Fog 6.5 and SMOG 5.0 (Eliminated the chart, answer choices for question #s 1, 9-11 and all the answer lines) by MKC

Medi-Cal CalOptima
A Public Agency
Better. Together.

CalOptima Children with Special Health Care Needs Assessment Mailing Date: [MM/DD/YYYY]

Dear Parent or Guardian:

We want to provide your child with access to good health care. Your answers to the questions on this survey will help us do that. We will only share your answers with those who are helping your child get better care such as your child's doctor. An older child may complete this survey on his or her own.

Filling out this survey will **not** stop your child from getting health care. If you need help to fill out this survey, please call toll-free at **1-888-587-8088**. We can get help for you over the phone. **Please complete and send us this survey as soon as you can.**

Child's Last Name:	Child's First Name:	Health Network:water
Child's CalOptima ID # (CIN):	Phone (Home):	Phone (Parent or Guardian Cell):
Address:		
Child's Height:	Child's Weight:	Today's Date:
Child's Date of Birth:		Child's Gender:

What to do:

a. Please read each question and mark the box like this: ☒ for your answer.
b. Some questions ask you to write an answer on the line. Please write your answer on the line next to the question. Thank you!

Survey completed by: □ Parent or Guardian □ Child or Member □ Other _____

Name of person completing this survey: _____
Please print

What is the best way for us to contact you? □ Phone □ Mail

What language do you prefer to speak?

□ English □ Spanish □ Vietnamese □ Arabic □ Farsi
□ Korean □ Mandarin □ Cantonese □ Other: _____

Do you have any other health insurance? □ Yes □ No
If yes, what other health insurance do you have? _____

Back to Agenda

CalOptima Children with Special Healthcare Needs Assessment

Current Health Care

1. **What health issues does your child have? (Mark an X in the box next to the issue that your child has or write it out)**

□ Asthma	□ Kidney problem with dialysis
□ ADD or ADHD	□ Down Syndrome
□ Autism or Autism Spectrum Disorder	□ Hearing problems
□ Severe behavioral problems	□ Heart problems
□ Blood problems	□ Learning problems
□ Bone/joint problems	□ Muscle problems
□ Cancer, type: _____	□ Prematurity or low birth weight
□ Cerebral Palsy	□ Seizure disorder or epilepsy
□ Cystic Fibrosis	□ Speech problems
□ Developmental delay	□ Vision problems
□ Diabetes	□ Other: _____

2. **Does your child get care from a specialist now? For example a specialist can be a lung doctor, a heart doctor, a mental health expert or any other doctors.**
   □ Yes □ No Name of doctor_____
   Type of doctor _____

3. **Has your child been told to get health care or services that you have not been able to get?**
   □ Yes □ No
   If yes, please list them here _____

4. **Does your child take any medicines daily (other than vitamins, iron, fluoride or things like that)?**
   □ Yes □ No

5. **Do you have any concerns about your child's health right now that are not being taken care of?**
   □ Yes □ No
   If yes, please list them here _____

Past Health History

6. **In the past 12 months, how many times has your child been in the hospital overnight?**
   □ None □ 1–2 times □ 3 times or more

7. **In the past 6 months, how many times did your child go to the emergency room and not spend the night?**
   □ None □ 1 time □ 2 times □ 3 times □ 4 or more times

Back to Agenda

8. **In the past 12 months, how many days did your child miss school due to health reasons?**
   □ 0–3 days □ 4–6 days □ 7–10 days □ More than 10 days □ Does not go to school

Daily Activity

9. **Due to his or her health, does your child need more help than other children their age with any of these? (Mark an X in the box next to the task your child needs extra help with.)**
   □ Bathing
   □ Eating
   □ Getting dressed
   □ None
   □ Using the toilet
   □ Walking
   □ Moving in and out of a bed or a chair

Care Received

10. **Does your child use any of these? (Mark an X in the box next to the item your child uses now.)**
    □ Apnea monitor
    □ Diabetes supplies (glucose meter, insulin pump)
    □ Braces or artificial limb(s)
    □ Diapers after age 4
    □ Feeding tube
    □ Hearing aids
    □ Oxygen
    □ Respirator or ventilator (machine that breathes for child)
    □ Speech board or other communication device
    □ Wheelchair, walker or stander
    □ Other: _____

11. **Does your child get any of this help now? (Mark an X in the box next to the help that your child gets now.)**
    □ Assistance from a transportation service
    □ Counseling for an emotional or behavioral problem
    □ Food assistance programs (WIC, CalFresh, food banks)
    □ Home health nurse on a long-term basis (more than 6 weeks)
    □ Physical, occupational or speech therapy
    □ Regional Center of Orange County (RCOC)
    □ Respite care
    □ Other community resource: _____

12. **Does your child need any help that he or she is not getting now?** □ Yes □ No
    If yes, please list the type of help they need _____

Social History

13. **How often do you or your family feel overwhelmed by caring for your child's health?**
    □A few times a week □ About once a month □ Every 6 months □ Never

14. Who gives you and your family help when you need it?
□ Friends and family □ Support group □ Church or faith-based group
□ No one □ Other _____

15. Where do you live now?
□ House or apartment □ Shelter □ Motel
□ Homeless □ Other: _____

Children ages 12 and older should complete the following section:

16. Over the past 2 weeks, how often have you been bothered by any of the following problems: Little interest or pleasure in doing things.
□ Not at all □ Several days □ More than half the day □ Nearly every day

17. Over the past 2 weeks, how often have you been bothered by any of the following problems: Feeling down, depressed or hopeless.
□ Not at all □ Several days □ More than half the day □ Nearly every day

18. Do you smoke, vape or use any tobacco now? □ Yes □ No

19. In the past 12 months, did you drink alcohol? Do not count sips of alcohol taken during family or religious events.
□ Yes □ No

20. In the past 12 months, did you use anything to get high? This includes illegal drugs, over-the-counter and prescription drugs and things you sniff or "huff."
□ Yes □ No

21. How often does anyone, including family, physically hurt you?
□ Never □ Rarely □ Sometimes □ Often

22. [This question is for girls only.] **Are you pregnant now?** □ Yes □ No

Thank you for taking time to complete this survey. Please fold and return it in the envelope we sent with this survey. We look forward to serving you and your child! If you have any questions about your child's doctor or health care, please call us toll-free at 1-888-587-8088, Monday through Friday, 8 a.m. to 5:30 p.m. TDD/TTY users can call toll-free at 1-800-735-2929. We have staff who speak your language.

Policy #:	GG.1531
Title:	**Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/09
Last Review Date:	~~08/01/17~~10/04/18
Last Revised Date:	~~08/01/17~~10/04/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy defines the criteria and process for coverage of a Wheelchair, Seating and Positioning Components (SPCs), and accessories for a Member.

II. POLICY

A. CalOptima or a Health Network shall provide a Wheelchair, Seating and Positioning Components (SPCs), and accessories for a Member when Medically Necessary.

B. CalOptima or a Health Network shall define Medically Necessary as reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, a Wheelchair, SPCs, and accessories prescribed for a Member may be a Covered Service and Medically Necessary when it is used in or out of a Member's home to:

1. Preserve bodily functions essential to Activities of Daily Living (ADL), Instrumental Activities of Daily Living (~~iADL~~IADL), or to prevent significant physical disability; or

2. Improve the medical status or functional ability of a Member, when a Member is not ambulatory or functionally ambulatory without static supports such as a cane, crutches, or walker, through the stabilization of the Member's condition, or the prevention of additional deterioration of the Member's medical status, or functional ability.

C. The following items are not Covered Services:

1. Modification of automobiles or other highway motor vehicles, with the exception of Automobile Orthopedic Positioning Devices (AOPDs) for eligible CalOptima Medi-Cal Members in accordance with CalOptima Policy GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices;

2. Orthopedic recliners, rockers, seat lift chairs, or other furniture items;

3. Household items; and

4. Other items not generally used primarily for health care and which are regularly and primarily used by an individual who does not have a specific medical need for such item.

D. CalOptima or a Health Network shall determine a Member's eligibility for a Wheelchair, SPCs, and accessories upon receipt of a written prescription for a Wheelchair, SPCs, and accessories by a Member's licensed Practitioner, within the Practitioner's scope of practice, as established by California law.

E. CalOptima or a Health Network shall provide one (1) of the following Wheelchairs, SPCs, and accessories to a Member:

1. Standard manual wheelchair;
2. Custom manual or powered wheelchair;
3. Custom lightweight manual, or powered, wheelchair;
4. Electric-powered wheelchair;
5. Power-assisted vehicle (POV) wheelchair;
6. Push rim activated device;
7. Power Mobility Devices (PMD);
8. Therapeutic seat cushions;
9. SPCs; or
10. Other related wheelchair accessories.

F. CalOptima and a Health Network shall authorize a Wheelchair, SPCs, and accessories for a Member, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals. The following provisions shall also apply:

1. A licensed Practitioner shall obtain Prior Authorization for the following Covered Services:
   a. Rental of a Wheelchair, SPCs, and accessories;
   b. Purchase of a Wheelchair, SPCs, and accessories; or
   c. Repair or maintenance of a Wheelchair, SPCs, and accessories exceeding a ~~cumulative~~total cost of two hundred fifty dollars ($250).
2. A licensed Practitioner shall utilize Department of Health Care Services (DHCS) clinical guidelines, as provided in DHCS All Plan Letter 15-018: Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components, to determine the appropriate device to meet the medical needs of a CalOptima Member.
3. A licensed Practitioner shall obtain Prior Authorization for the evaluation of a custom wheelchair prior to the purchase of a custom wheelchair and accessories.

4. A licensed Practitioner shall request Prior Authorization for a CalOptima Direct~~, or CalOptima Community Network (CCN),~~ Member, in accordance with this ~~policy~~Policy and CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers. A licensed Practitioner shall request Prior Authorization for a Health Network Member, in accordance with this policy and the Health Network's Prior Authorization procedures.

5. CalOptima or a Health Network shall refer a Member to a contracted wheelchair Evaluation Services Provider (ESP) for evaluation prior to authorizing a custom Wheelchair, SPCs, and accessories for the Member. In-home evaluation shall be the primary evaluation method for a custom Wheelchair, SPCs, and accessories. Use of a contracted seating clinic is appropriate in cases where an in-home evaluation may be impractical, or if the Member does not wish to have an evaluation conducted in his or her home.

6. If Medicare or Other Health Coverage (OHC) is the primary payer for the Wheelchair, SPCs, and accessories, the Practitioner and Provider are subject to Prior Authorization, as set forth in this policy and CalOptima Policies FF.2003: Coordination of Benefits, MA.3103: Claims Coordination of Benefits, and CMC.3103: Claims Coordination of Benefits.

7. CalOptima or a Health Network shall authorize one (1) Wheelchair per Member. If, at a later time, a Member requires a subsequent Wheelchair, SPCs, and accessories, CalOptima or a Health Network, may authorize a subsequent Wheelchair, SPCs, and accessories, in accordance with the provisions of this policy.

8. CalOptima or a Health Network may authorize the following Wheelchair, SPCs, and accessories for a Member who is an inpatient in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF):

    a. A Wheelchair, SPCs, and accessories are necessary for the continuous care and unusual medical needs of a Member. A Member may be considered to have unusual medical needs if a disease or medical condition is exacerbated by physical characteristics such as height, weight, and build. Physical characteristics~~, as such,~~ shall not constitute an unusual medical condition.

    b. A Wheelchair accessory that is custom made~~,~~ or modified~~,~~ to meet the unusual medical needs of a Member and the need is expected to be permanent.

9. CalOptima or a Health Network shall limit authorization for a Wheelchair, SPCs, and accessories to the lowest cost item that meets a Member's medical needs.

10. CalOptima or a Health Network shall not deny an authorization for a Wheelchair or SPCs for a Medi-Cal or OCC Member on the grounds it is for use outside of the home when determined to be Medically Necessary for the Member's medical condition.

11. CalOptima or a Health Network shall not grant an authorization for a Wheelchair, SPCs, and accessories if a household, or furniture, item shall adequately serve the Member's medical needs.

12. CalOptima or a Health Network shall not authorize a Wheelchair, SPCs, and accessories for a Member if the Member is in possession of a Wheelchair that already meets the Member's ADL

or IADL. If the Member's medical, or functional, needs have changed, the Member's Practitioner may submit a functional assessment containing medical justification for the Member's need for a new, adjusted, or modified Wheelchair.

13. CalOptima or a Health Network shall not authorize a Wheelchair, SPCs, and accessories for a Member if the Wheelchair, SPCs, and accessories are not Medically Necessary and needed solely for a social, educational, or vocational purpose. CalOptima shall refer the Member to the California State Department of Rehabilitation for Wheelchair, SPCs, and accessories requests based on vocational needs.

14. CalOptima or a Health Network shall not authorize a Wheelchair, SPCs, and accessories when:

    a. Not Medically Necessary;

    b. Not used by the Member;

    c. Used as a convenience item;

    d. Used to replace private, or public, transportation such as an automobile, bus, or taxi;

    e. Not used primarily for health care, and not regularly and primarily used by a Member who ~~does not have~~has a specific medical need;

    f. For PMDs, the underlying condition is reversible, and the length of need is less than three (3) months, such as following lower extremity surgery ~~which~~that limits ambulation;

    g. Used in a Facility that is expected to provide such items to a Member, except as specified in Section II.F.8. of this policy; or

    h. Not prescribed by a licensed Practitioner, or for custom Wheelchairs, a licensed Practitioner and an ESP.

15. CalOptima or a Health Network shall consider a Wheelchair, SPCs, and accessories to be purchased when previously paid rental charges equal the maximum allowable purchase price of the rented wheelchair and accessories. CalOptima shall provide no further reimbursement for the use of such Wheelchair, SPCs, and accessories, unless payment is for the subsequent repair and maintenance of the Wheelchair, SPCs, and accessories as authorized by CalOptima, or the Health Network. The cost ~~of repairs~~per repair shall not exceed the replacement value of the item being repaired.

16. CalOptima or a Health Network may audit Wheelchair authorization requests, as necessary, for appropriateness and accuracy.

G. A Member is responsible for the appropriate use and care of a Wheelchair, SPCs, and accessories rented or purchased for the Member's benefit.

H. Upon authorization to provide a Wheelchair, SPCs, and accessories for a Member, a Wheelchair Provider shall:

1. Provide a Wheelchair, SPCs, and accessories, in accordance with statutory, regulatory, contractual, CalOptima and Health Network policy, and other requirements related to the CalOptima program;

2. Ensure that the Wheelchair, SPCs, and accessories provided to a Member are appropriate for the Member's medical and functional needs. When necessary, the Wheelchair Provider shall adjust or modify the Wheelchair, SPCs, and accessories during the post-fitting period if the Wheelchair does not:

   a. Meet the Member's medical needs and the Member's medical condition has not changed since the date the Wheelchair was originally provided; or

   b. Meet the Member's functional needs when in actual use.

3. Replace any Wheelchair, SPCs and accessories that cannot be adjusted or modified during the post-fitting period of the Wheelchair at no cost to CalOptima or a Health Network.

III. PROCEDURE

A. Standard Wheelchair

1. A Member's Practitioner shall identify a Member who has a Medical Necessity for a standard Wheelchair rental or purchase and shall submit a complete authorization request with a written prescription to CalOptima's Utilization Management (UM) Department~~,~~ or the Health Network. Authorization request documentation shall include:

   a. Member's name, date of birth, phone number, address, and identification (ID) number;

   b. Full name, address, telephone number, and signature of the prescribing Practitioner;

   c. Date of request;

   d. For Medi-Cal and OCC Members, supporting documentation that the Member meets the Medical Necessity criteria for a standard Wheelchair in accordance with DHCS guidelines; and

   e. Specific item(s) requested, including Healthcare Common Procedure Coding System (HCPCS) codes.

2. CalOptima or a Health Network shall approve, modify, or deny an authorization for a standard Wheelchair, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

B. Manual or Powered Custom Wheelchair~~ -~~:

1. A Member's Practitioner shall identify a Member who has a Medical Necessity for a custom Wheelchair purchase and shall submit a complete authorization request to CalOptima's UM Department~~,~~ or the Health Network.

   a. For a CalOptima Direct ~~or CCN~~ Member the authorization request shall consist of the

Customized Wheelchair Evaluation Request Form (CWER) and Clinical Questionnaire. Authorization request documentation shall include:

i. Member's name, date of birth, phone number, address, and identification (ID) number;

ii. Full name, address, telephone number, and signature of the prescribing licensed Practitioner;

iii. Date of request;

iv. Specific items requested;

v. Supporting documentation that the Member meets the Medical Necessity criteria for a manual or powered custom Wheelchair, in accordance with DHCS guidelines; and

vi. Member's medical condition or diagnosis necessitating the custom Wheelchair, including:

a) Member's medical status and functional limitations; and

b) Description of how the requested custom Wheelchair is expected to improve the medical status or functional ability of the Member, stabilize the Member's medical condition, or prevent additional deterioration of the Member's medical status or functional ability.

b. For a Health Network Member, a Practitioner shall submit authorization request documentation~~,~~ in accordance with the Health Network's authorization procedures.

2. CalOptima's UM Department~~,~~ or the Health Network~~,~~ shall review the authorization request documentation submitted by a Member's Practitioner and, if incomplete, shall require the Practitioner to provide additional information.

3. CalOptima or a Health Network shall approve, modify, or deny an authorization for a custom wheelchair, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

4. If CalOptima or the Health Network approves the request for a customized wheelchair evaluation, CalOptima or the Health Network shall contact a contracted ESP to arrange an assessment in the Member's residence, or at a seating clinic.

5. ~~An~~ ESP staff shall submit a Letter of Recommendation (LOR) to CalOptima or the Health Network following its initial assessment. The LOR shall contain determination of Medical Necessity based on the standards set forth in Section II.B. of this ~~policy~~Policy, and the Member's unique medical needs and living environment.

6. CalOptima or the Health Network shall review the LOR and the licensed Practitioner's original Wheelchair request. If the recommendation on the LOR varies from the Practitioner's original request, CalOptima~~,~~ or the Health Network~~,~~ shall notify the Member and Member's Practitioner of such determination according to CalOptima Policy GG.1508: Authorization and Processing of Referrals.

7. If CalOptima or the Health Network approves a customized Wheelchair:

   a. For a CalOptima Direct ~~or CCN~~ Member, CalOptima shall forward the LOR, Clinical Questionnaire Form, and CWER Form, to a selected Wheelchair Provider.

   b. For a Health Network Member, the Health Network shall forward the LOR~~,~~ and authorization request~~,~~ to a selected Wheelchair Provider.

   c. CalOptima~~,~~ or the Health Network~~,~~ may select a contracted Wheelchair Provider that has a history with a Member to provide continuity of services.

      i. CalOptima or a Health Network shall provide Continuity of Care for a Member eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model (WCM) program with a Specialized or Customized Durable Medical Equipment (DME) provider for up to twelve (12) months, in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services. For Specialized or Customized DME under warranty, the Continuity of Care period may be extended to the duration of the warranty.

8. The selected Wheelchair Provider shall arrange a fitting appointment with the Member at the Member's residence~~,~~ or at a seating clinic.

9. The Wheelchair Provider shall obtain Prior Authorization to provide a customized Wheelchair to a Member by submitting an authorization request and a Wheelchair Quote that is signed and dated by the Member's Practitioner to CalOptima~~,~~ or the Health Network.

10. The Wheelchair Provider shall include the following information, at a minimum, in the Wheelchair Quote and prescription submitted to CalOptima~~,~~ or the Health Network:

    a. Member's name, date of birth, phone number, address, and identification (ID) number;

    b. Wheelchair Provider's name, address, telephone number, contact name and telephone number, and National Provider Identifier;

    c. Date of request; and

    d. Description of the Wheelchair and related items, including:

       i. Manufacturer name, model type or serial number, and purchase price;

       ii. Product description;

       iii. Billing and procedure codes, as applicable;

       iv. For unlisted or miscellaneous codes, copy of the catalogue page with price.

11. For an unlisted Wheelchair and accessories, the Member's Wheelchair Provider shall submit the following information:

a. Medical documentation justifying that the equipment is Medically Necessary and meets the Member's medical needs; and

b. Explanation of why a listed item does not meet the Member's medical needs and how the unlisted item best accommodates the Member's functional limitations and medical needs.

12. CalOptima or the Health Network shall review the authorization request and the signed Wheelchair Quote submitted by the Wheelchair Provider and, if incomplete, shall require the Member's Practitioner, or Wheelchair Provider to provide additional information.

13. If CalOptima or the Health Network approves the custom Wheelchair, CalOptima or the Health Network shall send a letter of authorization to the contracted custom Wheelchair Provider. Upon receipt, the Wheelchair Provider shall assemble the custom wheelchair in accordance with the authorization.

14. Upon completion of the Wheelchair, the Wheelchair Provider shall provide a post-fitting at the Member's residence~~,~~ or at the seating clinic~~,~~ to ensure that the Member's Wheelchair meets the medical and functional needs of the Member.

15. Upon receipt of the signed delivery ticket from the contracted Wheelchair Provider and confirmation that the Member's Wheelchair meets the medical and functional needs of the Member, CalOptima~~,~~ or the Health Network~~,~~ shall process the claim for payment.

C. Seating and Positioning Component

1. A Member may be eligible to receive SPCs when Medically Necessary, and, for Medi-Cal and OCC Members, pursuant to DHCS guidance.

2. A licensed Practitioner and shall submit a complete authorization request with a written prescription to CalOptima's Utilization Management (UM) Department~~,~~ or the Health Network. Authorization request documentation shall include:

a. Member's name, date of birth, phone number, address, and identification (ID) number;

b. Full name, address, telephone number, and signature of the prescribing licensed Practitioner;

c. Date of request;

d. For Medi-Cal and OCC Members, supporting documentation that the Member meets the Medical Necessity criteria for SPCs, in accordance with DHCS guidelines; and

e. Specific item(s) requested, including Healthcare Common Procedure Coding System (HCPCS) codes.

3. CalOptima or a Health Network shall approve, modify, or deny an authorization for SPCs, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

~~C.~~D. Wheelchair Repair

1. A Wheelchair repair request with a ~~cumulative~~total cost of less than two hundred fifty dollars ($250), that is a Covered Service, and that does not exceed frequency limitations, shall not require a Prior Authorization.

   ~~1.~~a. For a CalOptima Direct ~~or CCN~~ Member, CalOptima shall reimburse such repair pursuant to all applicable claims requirements, in accordance with CalOptima Policies FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group and CMC.3101: Claims Processing.

   b. For a Health Network Member, a Health Network shall reimburse such repair pursuant to all applicable claims requirements.

2. A Member's Practitioner shall complete a Wheelchair repair authorization request for a Wheelchair repair exceeding a ~~cumulative~~total cost of two hundred fifty dollars ($250). Documentation shall include:

   a. Member's name, date of birth, phone number, address, and identification (ID) number;

   b. Full name, address, telephone number, and signature of the prescribing Practitioner;

   c. Date of request; and

   d. Description of the repair, or maintenance, required.

3. Upon submission of the Wheelchair repair authorization request, CalOptima's UM Department~~,~~ or the Health Network~~,~~ shall review the request for benefit coverage, frequency limitations, and Medical Necessity. CalOptima~~,~~ or the Health Network~~,~~ shall approve, modify, or deny a Wheelchair repair authorization, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

E. Medical Therapy Program - California Children's Services (CCS)/Whole Child Model Program (WCM) Members

1. Effective January 1, 2019, for Members eligible with the CCS Program who participate in the Orange County CCS Medical Therapy Program (MTP), the MTP shall submit all requests for Wheelchairs and Wheelchair repairs with a total cost of over $250 to CalOptima. The request will include:

   a. Completed Custom Wheelchair Authorization Referral Form, if applicable;

   b. Signed prescription/provider order for the requested Wheelchair; and

   c. Wheelchair specifications, HCPCS codes and pricing from the Wheelchair vendor that have been reviewed/confirmed by Medical Therapy Unit (MTU) therapist/supervisor.

2. CalOptima will review and triage these requests to CalOptima or the Health Network Prior Authorization staff via secure communication.

3. If a referral for a Wheelchair or Wheelchair repair for a CCS-eligible Member is received by

CalOptima or a Health Network directly from a vendor and not from the MTU, the request will be denied, and the Member referred to the MTU for evaluation.

4. If the Member requests a Wheelchair or a Wheelchair repair that the MTU does not recommend, the MTU will notify CalOptima who will issue or instruct the Health Network to issue the appropriate Notice of Action letter.

5. For Wheelchairs or Wheelchair repairs that are covered and recommended by the MTU, CalOptima or a Health Network will approve the Wheelchair request in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and CalOptima Policy GG.1508: Authorization and Processing of Referrals.

6. Following approval, CalOptima or a Health Network will notify the requesting provider, the Member's MTP and Wheelchair Provider within standard prior authorization turn around-time requirements for Wheelchair requests.

7. Effective January 1, 2019, for all other CCS-eligible Members, Wheelchair-related requests will be processed in the same manner as provided for non-CCS Members in this Policy, except with regard to Continuity of Care as described in Section III.B.7.c.i. of this Policy.

IV. ATTACHMENTS

A. CalOptima Authorization Request Form (ARF)
B. Customized Wheelchair Evaluation Request (CWER) Form
C. Clinical Questionnaire: Referring Physician Authorization for New Wheelchair
D. Wheelchair Repairs Authorization Referral Form
~~E. CalOptima Customized Wheelchair Authorization Process Flowchart~~
~~F. CalOptima Wheelchair Repair Process Flowchart~~

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~C.~~D. CalOptima Contract for Wheelchair Services
~~D.~~E. CalOptima Health Network Service Agreement
~~E.~~F. CalOptima Policy CMC.3103: Claims Coordination of Benefits
~~F.~~G. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
~~G.~~H. CalOptima Policy FF.2003: Coordination of Benefits
I. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
~~H.~~J. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
~~I.~~K. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~J.~~L. CalOptima Policy MA.3103: Claims Coordination of Benefits

~~K. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~

~~L.~~M. Centers for Medicare & Medicaid Services (CMS) Managed Care Manual (MCM) Chapter 4, Section 10.12: Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

~~M.~~N. Department of Health Care Services All Plan Letter (APL) 15-018: Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components, including DHCS Guidance: Durable Medical Equipment: Wheelchair and Wheelchair Accessories

~~N.~~O. Department of Health Care Services Medi-Cal Allied Health Provider Manual Durable Medical Equipment (DME): An Overview

P. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program

~~O.~~Q. McKesson Health Solutions InterQual Level of Care Criteria

~~P.~~R. Title 22, California Code of Regulations (CCR.), §§ 51303, 51104, 51160, and 51321

~~Q.~~S. Welfare and Institutions Code, §14105.485

VI. REGULATORY AGENCY APPROVALS

A. 12/10/15: Department of Health Care Services

VII. BOARD ACTIONS

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

B. 07/10/08: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2009	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal
Revised	01/01/2010	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal
Revised	08/01/2015	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect
Non-Substantive Edit	05/10/2016	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	10/04/2018	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect

1

IX. GLOSSARY

Term	Definition
Activities of Daily Living (ADL)	Dressing/bathing, eating ambulating (walking), toileting and hygiene.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Custom Wheelchair	For the purposes of this policy, refers to those wheelchairs which are specialized, requiring an evaluation be done by a Seating Clinic prior to submitting an Authorization Request Form to a contracted vendor who is able to provide the wheelchair customization needed for the member.
Durable Medical Equipment	Any equipment that is prescribed by a licensed Practitioner to meet the medical equipment needs of the Member that: 1. Can withstand repeated use; 2. Is used to serve a medical purpose; 3. Is not useful to a Member in the absence of an illness, injury, functional impairment or congenital anomaly; and 4. Is appropriate for use in or outside of the Member's home.
Evaluation Services Provider (ESP)	A professional who has specific training and/or experience in Wheelchair evaluation and ordering.
Health Network	A Physician Medical Group (PMG), 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.
Instrumental Activities of Daily Living (IADL)	Those activities that allow a Member to live independently in a community and include shopping, housekeeping, accounting, food preparation, taking medications as prescribed, use of a telephone or other form of communication, and accessing transportation within the Member's community.
Intermediate Care Facility (ICF)	Medi-Cal: A health facility that is licensed as such by the Department of Health Care Services (DHCS) or is a hospital or SNF that meets the standards specified in Title 22, California Code of Regulations, Section 51212, and has been certified by DHCS for participation in the Medi-Cal program. Medicare: A facility that primarily provides health-related care and services above the level of custodial care but does not provide the level of care available in a hospital or Skilled Nursing Facility.
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.
Member	An enrollee-beneficiary of a CalOptima program.

Term	Definition
Other Health Coverage (OHC)	Medi-Cal: The responsibility of an individual or entity, other than CalOptima or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal Obligation, excluding tort liability. OneCare/OneCare Connect: Evidence of health coverage other than OneCare/OneCare Connect including, but not necessarily limited to: 1. The CalOptima Medi-Cal program; 2. Group health plans; 3. Federal Employee Health Benefits Program (FEHB); 4. Military coverage, including TRICARE; 5. Worker's Compensation; 6. Personal Injury Liability compensation; 7. Black Lung federal coverage; 8. Indian Health Service; 9. Federally qualified health centers (FQHC); 10. Rural health centers (RHC); and 11. Other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of Covered Part D Drugs on behalf of Part D eligible individuals as the Centers for Medicare & Medicaid Services (CMS) may specify.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.
Seating and Positioning Components (SPC)	Seat, back and positioning equipment mounted to the Wheelchair base.
Seating Clinic	A CalOptima contracted utilization management evaluation by a multidisciplinary team led by a principal therapist to evaluate a Member's needs for a Custom Seating System, recommend the most appropriate Custom Seating System, fit the Custom Seating System, and Report UM activity.

Term	Definition
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/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.
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
Standard Wheelchair	For the purposes of this policy, refers to those wheelchairs that are available through any contracted vendor that provides wheelchair rentals on a short term basis, or for purchase. These wheelchairs do not require an evaluation by the Seating Clinic and are typically for short term use and are not customizable.
Wheelchair	A wheelchair may be a: 1. Manual wheelchair; 2. Power mobility device (PMD); 3. Power-assisted vehicle (POV); or 4. Push rim activated device.
Wheelchair Provider	A contracted provider, acting within his or her scope of practice, to furnish wheelchairs, SPCs, and related accessories to Members. The Wheelchair Provider ensures the Wheelchair, SPCs, and accessories furnished are appropriate for the Member's medical and functional needs and may adjust or modify the furnished items as appropriate.

Policy #:	GG.1531
Title:	**Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/09
Last Review Date:	10/04/18
Last Revised Date:	10/04/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy defines the criteria and process for coverage of a Wheelchair, Seating and Positioning Components (SPCs), and accessories for a Member.

II. POLICY

A. CalOptima or a Health Network shall provide a Wheelchair, Seating and Positioning Components (SPCs), and accessories for a Member when Medically Necessary.

B. CalOptima or a Health Network shall define Medically Necessary as reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, a Wheelchair, SPCs, and accessories prescribed for a Member may be a Covered Service and Medically Necessary when it is used in or out of a Member's home to:

1. Preserve bodily functions essential to Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), or to prevent significant physical disability; or

2. Improve the medical status or functional ability of a Member, when a Member is not ambulatory or functionally ambulatory without static supports such as a cane, crutches, or walker, through the stabilization of the Member's condition, or the prevention of additional deterioration of the Member's medical status, or functional ability.

C. The following items are not Covered Services:

1. Modification of automobiles or other highway motor vehicles, with the exception of Automobile Orthopedic Positioning Devices (AOPDs) for eligible CalOptima Medi-Cal Members in accordance with CalOptima Policy GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices;

2. Orthopedic recliners, rockers, seat lift chairs, or other furniture items;

3. Household items; and

4. Other items not generally used primarily for health care and which are regularly and primarily used by an individual who does not have a specific medical need for such item.

D. CalOptima or a Health Network shall determine a Member's eligibility for a Wheelchair, SPCs, and accessories upon receipt of a written prescription for a Wheelchair, SPCs, and accessories by a Member's licensed Practitioner, within the Practitioner's scope of practice, as established by California law.

E. CalOptima or a Health Network shall provide one (1) of the following Wheelchairs, SPCs, and accessories to a Member:

1. Standard manual wheelchair;
2. Custom manual or powered wheelchair;
3. Custom lightweight manual, or powered, wheelchair;
4. Electric-powered wheelchair;
5. Power-assisted vehicle (POV) wheelchair;
6. Push rim activated device;
7. Power Mobility Devices (PMD);
8. Therapeutic seat cushions;
9. SPCs; or
10. Other related wheelchair accessories.

F. CalOptima and a Health Network shall authorize a Wheelchair, SPCs, and accessories for a Member, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals. The following provisions shall also apply:

1. A licensed Practitioner shall obtain Prior Authorization for the following Covered Services:
   a. Rental of a Wheelchair, SPCs, and accessories;
   b. Purchase of a Wheelchair, SPCs, and accessories; or
   c. Repair or maintenance of a Wheelchair, SPCs, and accessories exceeding a total cost of two hundred fifty dollars ($250).
2. A licensed Practitioner shall utilize Department of Health Care Services (DHCS) clinical guidelines, as provided in DHCS All Plan Letter 15-018: Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components, to determine the appropriate device to meet the medical needs of a CalOptima Member.
3. A licensed Practitioner shall obtain Prior Authorization for the evaluation of a custom wheelchair prior to the purchase of a custom wheelchair and accessories.

4. A licensed Practitioner shall request Prior Authorization for a CalOptima Direct Member, in accordance with this Policy and CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers. A licensed Practitioner shall request Prior Authorization for a Health Network Member, in accordance with this policy and the Health Network's Prior Authorization procedures.

5. CalOptima or a Health Network shall refer a Member to a contracted wheelchair Evaluation Services Provider (ESP) for evaluation prior to authorizing a custom Wheelchair, SPCs, and accessories for the Member. In-home evaluation shall be the primary evaluation method for a custom Wheelchair, SPCs, and accessories. Use of a contracted seating clinic is appropriate in cases where an in-home evaluation may be impractical, or if the Member does not wish to have an evaluation conducted in his or her home.

6. If Medicare or Other Health Coverage (OHC) is the primary payer for the Wheelchair, SPCs, and accessories, the Practitioner and Provider are subject to Prior Authorization, as set forth in this policy and CalOptima Policies FF.2003: Coordination of Benefits, MA.3103: Claims Coordination of Benefits, and CMC.3103: Claims Coordination of Benefits.

7. CalOptima or a Health Network shall authorize one (1) Wheelchair per Member. If, at a later time, a Member requires a subsequent Wheelchair, SPCs, and accessories, CalOptima or a Health Network, may authorize a subsequent Wheelchair, SPCs, and accessories, in accordance with the provisions of this policy.

8. CalOptima or a Health Network may authorize the following Wheelchair, SPCs, and accessories for a Member who is an inpatient in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF):

    a. A Wheelchair, SPCs, and accessories are necessary for the continuous care and unusual medical needs of a Member. A Member may be considered to have unusual medical needs if a disease or medical condition is exacerbated by physical characteristics such as height, weight, and build. Physical characteristics shall not constitute an unusual medical condition.

    b. A Wheelchair accessory that is custom made or modified to meet the unusual medical needs of a Member and the need is expected to be permanent.

9. CalOptima or a Health Network shall limit authorization for a Wheelchair, SPCs, and accessories to the lowest cost item that meets a Member's medical needs.

10. CalOptima or a Health Network shall not deny an authorization for a Wheelchair or SPCs for a Medi-Cal or OCC Member on the grounds it is for use outside of the home when determined to be Medically Necessary for the Member's medical condition.

11. CalOptima or a Health Network shall not grant an authorization for a Wheelchair, SPCs, and accessories if a household, or furniture, item shall adequately serve the Member's medical needs.

12. CalOptima or a Health Network shall not authorize a Wheelchair, SPCs, and accessories for a Member if the Member is in possession of a Wheelchair that already meets the Member's ADL or IADL. If the Member's medical, or functional, needs have changed, the Member's

Practitioner may submit a functional assessment containing medical justification for the Member's need for a new, adjusted, or modified Wheelchair.

13. CalOptima or a Health Network shall not authorize a Wheelchair, SPCs, and accessories for a Member if the Wheelchair, SPCs, and accessories are not Medically Necessary and needed solely for a social, educational, or vocational purpose. CalOptima shall refer the Member to the California State Department of Rehabilitation for Wheelchair, SPCs, and accessories requests based on vocational needs.

14. CalOptima or a Health Network shall not authorize a Wheelchair, SPCs, and accessories when:

    a. Not Medically Necessary;

    b. Not used by the Member;

    c. Used as a convenience item;

    d. Used to replace private, or public, transportation such as an automobile, bus, or taxi;

    e. Not used primarily for health care, and not regularly and primarily used by a Member who has a specific medical need;

    f. For PMDs, the underlying condition is reversible, and the length of need is less than three (3) months, such as following lower extremity surgery that limits ambulation;

    g. Used in a Facility that is expected to provide such items to a Member, except as specified in Section II.F.8. of this policy; or

    h. Not prescribed by a licensed Practitioner, or for custom Wheelchairs, a licensed Practitioner and an ESP.

15. CalOptima or a Health Network shall consider a Wheelchair, SPCs, and accessories to be purchased when previously paid rental charges equal the maximum allowable purchase price of the rented wheelchair and accessories. CalOptima shall provide no further reimbursement for the use of such Wheelchair, SPCs, and accessories, unless payment is for the subsequent repair and maintenance of the Wheelchair, SPCs, and accessories as authorized by CalOptima, or the Health Network. The cost per repair shall not exceed the replacement value of the item being repaired.

16. CalOptima or a Health Network may audit Wheelchair authorization requests, as necessary, for appropriateness and accuracy.

G. A Member is responsible for the appropriate use and care of a Wheelchair, SPCs, and accessories rented or purchased for the Member's benefit.

H. Upon authorization to provide a Wheelchair, SPCs, and accessories for a Member, a Wheelchair Provider shall:

1. Provide a Wheelchair, SPCs, and accessories, in accordance with statutory, regulatory, contractual, CalOptima and Health Network policy, and other requirements related to the CalOptima program;

2. Ensure that the Wheelchair, SPCs, and accessories provided to a Member are appropriate for the Member's medical and functional needs. When necessary, the Wheelchair Provider shall adjust or modify the Wheelchair, SPCs, and accessories during the post-fitting period if the Wheelchair does not:

   a. Meet the Member's medical needs and the Member's medical condition has not changed since the date the Wheelchair was originally provided; or

   b. Meet the Member's functional needs when in actual use.

3. Replace any Wheelchair, SPCs and accessories that cannot be adjusted or modified during the post-fitting period of the Wheelchair at no cost to CalOptima or a Health Network.

III. PROCEDURE

A. Standard Wheelchair

1. A Member's Practitioner shall identify a Member who has a Medical Necessity for a standard Wheelchair rental or purchase and shall submit a complete authorization request with a written prescription to CalOptima's Utilization Management (UM) Department or the Health Network. Authorization request documentation shall include:

   a. Member's name, date of birth, phone number, address, and identification (ID) number;

   b. Full name, address, telephone number, and signature of the prescribing Practitioner;

   c. Date of request;

   d. For Medi-Cal and OCC Members, supporting documentation that the Member meets the Medical Necessity criteria for a standard Wheelchair in accordance with DHCS guidelines; and

   e. Specific item(s) requested, including Healthcare Common Procedure Coding System (HCPCS) codes.

2. CalOptima or a Health Network shall approve, modify, or deny an authorization for a standard Wheelchair, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

B. Manual or Powered Custom Wheelchair:

1. A Member's Practitioner shall identify a Member who has a Medical Necessity for a custom Wheelchair purchase and shall submit a complete authorization request to CalOptima's UM Department or the Health Network.

   a. For a CalOptima Direct Member the authorization request shall consist of the Customized

Wheelchair Evaluation Request Form (CWER) and Clinical Questionnaire. Authorization request documentation shall include:

i. Member's name, date of birth, phone number, address, and identification (ID) number;

ii. Full name, address, telephone number, and signature of the prescribing licensed Practitioner;

iii. Date of request;

iv. Specific items requested;

v. Supporting documentation that the Member meets the Medical Necessity criteria for a manual or powered custom Wheelchair, in accordance with DHCS guidelines; and

vi. Member's medical condition or diagnosis necessitating the custom Wheelchair, including:

a) Member's medical status and functional limitations; and

b) Description of how the requested custom Wheelchair is expected to improve the medical status or functional ability of the Member, stabilize the Member's medical condition, or prevent additional deterioration of the Member's medical status or functional ability.

b. For a Health Network Member, a Practitioner shall submit authorization request documentation in accordance with the Health Network's authorization procedures.

2. CalOptima's UM Department or the Health Network shall review the authorization request documentation submitted by a Member's Practitioner and, if incomplete, shall require the Practitioner to provide additional information.

3. CalOptima or a Health Network shall approve, modify, or deny an authorization for a custom wheelchair, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

4. If CalOptima or the Health Network approves the request for a customized wheelchair evaluation, CalOptima or the Health Network shall contact a contracted ESP to arrange an assessment in the Member's residence, or at a seating clinic.

5. ESP staff shall submit a Letter of Recommendation (LOR) to CalOptima or the Health Network following its initial assessment. The LOR shall contain determination of Medical Necessity based on the standards set forth in Section II.B. of this Policy, and the Member's unique medical needs and living environment.

6. CalOptima or the Health Network shall review the LOR and the licensed Practitioner's original Wheelchair request. If the recommendation on the LOR varies from the Practitioner's original request, CalOptima or the Health Network shall notify the Member and Member's Practitioner of such determination according to CalOptima Policy GG.1508: Authorization and Processing of Referrals.

7. If CalOptima or the Health Network approves a customized Wheelchair:

    a. For a CalOptima Direct Member, CalOptima shall forward the LOR, Clinical Questionnaire Form, and CWER Form, to a selected Wheelchair Provider.

    b. For a Health Network Member, the Health Network shall forward the LOR and authorization request to a selected Wheelchair Provider.

    c. CalOptima or the Health Network may select a contracted Wheelchair Provider that has a history with a Member to provide continuity of services.

        i. CalOptima or a Health Network shall provide Continuity of Care for a Member eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model (WCM) program with a Specialized or Customized Durable Medical Equipment (DME) provider for up to twelve (12) months, in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services. For Specialized or Customized DME under warranty, the Continuity of Care period may be extended to the duration of the warranty.

8. The selected Wheelchair Provider shall arrange a fitting appointment with the Member at the Member's residence or at a seating clinic.

9. The Wheelchair Provider shall obtain Prior Authorization to provide a customized Wheelchair to a Member by submitting an authorization request and a Wheelchair Quote that is signed and dated by the Member's Practitioner to CalOptima or the Health Network.

10. The Wheelchair Provider shall include the following information, at a minimum, in the Wheelchair Quote and prescription submitted to CalOptima or the Health Network:

    a. Member's name, date of birth, phone number, address, and identification (ID) number;

    b. Wheelchair Provider's name, address, telephone number, contact name and telephone number, and National Provider Identifier;

    c. Date of request; and

    d. Description of the Wheelchair and related items, including:

        i. Manufacturer name, model type or serial number, and purchase price;

        ii. Product description;

        iii. Billing and procedure codes, as applicable;

        iv. For unlisted or miscellaneous codes, copy of the catalogue page with price.

11. For an unlisted Wheelchair and accessories, the Member's Wheelchair Provider shall submit the following information:

a. Medical documentation justifying that the equipment is Medically Necessary and meets the Member's medical needs; and

b. Explanation of why a listed item does not meet the Member's medical needs and how the unlisted item best accommodates the Member's functional limitations and medical needs.

12. CalOptima or the Health Network shall review the authorization request and the signed Wheelchair Quote submitted by the Wheelchair Provider and, if incomplete, shall require the Member's Practitioner, or Wheelchair Provider to provide additional information.

13. If CalOptima or the Health Network approves the custom Wheelchair, CalOptima or the Health Network shall send a letter of authorization to the contracted custom Wheelchair Provider. Upon receipt, the Wheelchair Provider shall assemble the custom wheelchair in accordance with the authorization.

14. Upon completion of the Wheelchair, the Wheelchair Provider shall provide a post-fitting at the Member's residence or at the seating clinic to ensure that the Member's Wheelchair meets the medical and functional needs of the Member.

15. Upon receipt of the signed delivery ticket from the contracted Wheelchair Provider and confirmation that the Member's Wheelchair meets the medical and functional needs of the Member, CalOptima or the Health Network shall process the claim for payment.

C. Seating and Positioning Component

1. A Member may be eligible to receive SPCs when Medically Necessary, and, for Medi-Cal and OCC Members, pursuant to DHCS guidance.

2. A licensed Practitioner and shall submit a complete authorization request with a written prescription to CalOptima's Utilization Management (UM) Department or the Health Network. Authorization request documentation shall include:

a. Member's name, date of birth, phone number, address, and identification (ID) number;

b. Full name, address, telephone number, and signature of the prescribing licensed Practitioner;

c. Date of request;

d. For Medi-Cal and OCC Members, supporting documentation that the Member meets the Medical Necessity criteria for SPCs, in accordance with DHCS guidelines; and

e. Specific item(s) requested, including Healthcare Common Procedure Coding System (HCPCS) codes.

3. CalOptima or a Health Network shall approve, modify, or deny an authorization for SPCs, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

D. Wheelchair Repair

1. A Wheelchair repair request with a total cost of less than two hundred fifty dollars ($250), that is a Covered Service, and that does not exceed frequency limitations, shall not require a Prior Authorization.

    a. For a CalOptima Direct Member, CalOptima shall reimburse such repair pursuant to all applicable claims requirements, in accordance with CalOptima Policies FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group and CMC.3101: Claims Processing.

    b. For a Health Network Member, a Health Network shall reimburse such repair pursuant to all applicable claims requirements.

2. A Member's Practitioner shall complete a Wheelchair repair authorization request for a Wheelchair repair exceeding a total cost of two hundred fifty dollars ($250). Documentation shall include:

    a. Member's name, date of birth, phone number, address, and identification (ID) number;

    b. Full name, address, telephone number, and signature of the prescribing Practitioner;

    c. Date of request; and

    d. Description of the repair, or maintenance, required.

3. Upon submission of the Wheelchair repair authorization request, CalOptima's UM Department or the Health Network shall review the request for benefit coverage, frequency limitations, and Medical Necessity. CalOptima or the Health Network shall approve, modify, or deny a Wheelchair repair authorization, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

E. Medical Therapy Program - California Children's Services (CCS)/Whole Child Model Program (WCM) Members

1. Effective January 1, 2019, for Members eligible with the CCS Program who participate in the Orange County CCS Medical Therapy Program (MTP), the MTP shall submit all requests for Wheelchairs and Wheelchair repairs with a total cost of over $250 to CalOptima. The request will include:

    a. Completed Custom Wheelchair Authorization Referral Form, if applicable;

    b. Signed prescription/provider order for the requested Wheelchair; and

    c. Wheelchair specifications, HCPCS codes and pricing from the Wheelchair vendor that have been reviewed/confirmed by Medical Therapy Unit (MTU) therapist/supervisor.

2. CalOptima will review and triage these requests to CalOptima or the Health Network Prior Authorization staff via secure communication.

3. If a referral for a Wheelchair or Wheelchair repair for a CCS-eligible Member is received by

CalOptima or a Health Network directly from a vendor and not from the MTU, the request will be denied, and the Member referred to the MTU for evaluation.

4. If the Member requests a Wheelchair or a Wheelchair repair that the MTU does not recommend, the MTU will notify CalOptima who will issue or instruct the Health Network to issue the appropriate Notice of Action letter.

5. For Wheelchairs or Wheelchair repairs that are covered and recommended by the MTU, CalOptima or a Health Network will approve the Wheelchair request in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and CalOptima Policy GG.1508: Authorization and Processing of Referrals.

6. Following approval, CalOptima or a Health Network will notify the requesting provider, the Member's MTP and Wheelchair Provider within standard prior authorization turn around-time requirements for Wheelchair requests.

7. Effective January 1, 2019, for all other CCS-eligible Members, Wheelchair-related requests will be processed in the same manner as provided for non-CCS Members in this Policy, except with regard to Continuity of Care as described in Section III.B.7.c.i. of this Policy.

IV. ATTACHMENTS

A. CalOptima Authorization Request Form (ARF)
B. Customized Wheelchair Evaluation Request (CWER) Form
C. Clinical Questionnaire: Referring Physician Authorization for New Wheelchair
D. Wheelchair Repairs Authorization Referral Form

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Contract for Wheelchair Services
E. CalOptima Health Network Service Agreement
F. CalOptima Policy CMC.3103: Claims Coordination of Benefits
G. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
H. CalOptima Policy FF.2003: Coordination of Benefits
I. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
J. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
K. CalOptima Policy GG.1508: Authorization and Processing of Referrals
L. CalOptima Policy MA.3103: Claims Coordination of Benefits
M. Centers for Medicare & Medicaid Services (CMS) Managed Care Manual (MCM) Chapter 4, Section 10.12: Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

N. Department of Health Care Services All Plan Letter (APL) 15-018: Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components, including DHCS Guidance: Durable Medical Equipment: Wheelchair and Wheelchair Accessories
O. Department of Health Care Services Medi-Cal Allied Health Provider Manual Durable Medical Equipment (DME): An Overview
P. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program
Q. McKesson Health Solutions InterQual Level of Care Criteria
R. Title 22, California Code of Regulations (CCR.), §§ 51303, 51104, 51160, and 51321
S. Welfare and Institutions Code, §14105.485

VI. REGULATORY AGENCY APPROVALS

A. 12/10/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors
B. 07/10/08: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2009	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal
Revised	01/01/2010	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal
Revised	08/01/2015	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect
Non-Substantive Edit	05/10/2016	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect
Revised	10/04/2018	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Activities of Daily Living (ADL)	Dressing/bathing, eating ambulating (walking), toileting and hygiene.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Custom Wheelchair	For the purposes of this policy, refers to those wheelchairs which are specialized, requiring an evaluation be done by a Seating Clinic prior to submitting an Authorization Request Form to a contracted vendor who is able to provide the wheelchair customization needed for the member.
Durable Medical Equipment	Any equipment that is prescribed by a licensed Practitioner to meet the medical equipment needs of the Member that: 1. Can withstand repeated use; 2. Is used to serve a medical purpose; 3. Is not useful to a Member in the absence of an illness, injury, functional impairment or congenital anomaly; and 4. Is appropriate for use in or outside of the Member's home.
Evaluation Services Provider (ESP)	A professional who has specific training and/or experience in Wheelchair evaluation and ordering.
Health Network	A Physician Medical Group (PMG), 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.
Instrumental Activities of Daily Living (IADL)	Those activities that allow a Member to live independently in a community and include shopping, housekeeping, accounting, food preparation, taking medications as prescribed, use of a telephone or other form of communication, and accessing transportation within the Member's community.
Intermediate Care Facility (ICF)	Medi-Cal: A health facility that is licensed as such by the Department of Health Care Services (DHCS) or is a hospital or SNF that meets the standards specified in Title 22, California Code of Regulations, Section 51212, and has been certified by DHCS for participation in the Medi-Cal program. Medicare: A facility that primarily provides health-related care and services above the level of custodial care but does not provide the level of care available in a hospital or Skilled Nursing Facility.
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.
Member	An enrollee-beneficiary of a CalOptima program.

Term	Definition
Other Health Coverage (OHC)	Medi-Cal: The responsibility of an individual or entity, other than CalOptima or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal Obligation, excluding tort liability. OneCare/OneCare Connect: Evidence of health coverage other than OneCare/OneCare Connect including, but not necessarily limited to: 1. The CalOptima Medi-Cal program; 2. Group health plans; 3. Federal Employee Health Benefits Program (FEHB); 4. Military coverage, including TRICARE; 5. Worker's Compensation; 6. Personal Injury Liability compensation; 7. Black Lung federal coverage; 8. Indian Health Service; 9. Federally qualified health centers (FQHC); 10. Rural health centers (RHC); and 11. Other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of Covered Part D Drugs on behalf of Part D eligible individuals as the Centers for Medicare & Medicaid Services (CMS) may specify.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.
Seating and Positioning Components (SPC)	Seat, back and positioning equipment mounted to the Wheelchair base.
Seating Clinic	A CalOptima contracted utilization management evaluation by a multidisciplinary team led by a principal therapist to evaluate a Member's needs for a Custom Seating System, recommend the most appropriate Custom Seating System, fit the Custom Seating System, and Report UM activity.

Term	Definition
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/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.
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
Standard Wheelchair	For the purposes of this policy, refers to those wheelchairs that are available through any contracted vendor that provides wheelchair rentals on a short term basis, or for purchase. These wheelchairs do not require an evaluation by the Seating Clinic and are typically for short term use and are not customizable.
Wheelchair	A wheelchair may be a: 1. Manual wheelchair; 2. Power mobility device (PMD); 3. Power-assisted vehicle (POV); or 4. Push rim activated device.
Wheelchair Provider	A contracted provider, acting within his or her scope of practice, to furnish wheelchairs, SPCs, and related accessories to Members. The Wheelchair Provider ensures the Wheelchair, SPCs, and accessories furnished are appropriate for the Member's medical and functional needs and may adjust or modify the furnished items as appropriate.

1

P.O. BOX 11033 ORANGE, CA 92856 Phone: (714) 246-8686

AUTHORIZATION REQUEST FORM (ARF)

☐ ROUTINE Fax to (714) 246-8579 ☐ RETRO Fax to (714) 246-8579

*** IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETED AND LEGIBLE ***

PROVIDER: Authorization does not guarantee payment, ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ ☐ M ☐ F D.O.B. _____ Age: _____
Last First

Mailing Address: _____ City: _____ ZIP: _____ Phone: _____

Client Index # (CIN): _____ Name of ICF/SNF (if applicable): _____

Referring Provider:	Provider Rendering Service (Physician, Facility, Vendor):
Provider NPI#: _____ TIN#: _____ Medi-Cal ID#: _____	Provider NPI#: _____ TIN#: _____ Medi-Cal ID#: _____
Address: Phone: _____ Fax:	Address: Phone: _____ Fax:
Office Contact: _____ Physician's Signature: _____	Office Contact: _____
Diagnosis: _____	ICD-10: _____

AUTHORIZATION REQUEST

☐ URGENT REQUEST Fax to (714) 338-3137. ***Definition: "Urgent" is ONLY when normal time frame for authorization will be detrimental to patient's life or health, jeopardize patient's ability to regain maximum function, or result in loss of life, limb or other major bodily function. Urgent requests are addressed within 72 hours.***

☐ Inpatient Facility ☐Outpatient Facility ☐ SNF Estimated Length of Stay: _____

Date(s) of Services: _____ Retro Date(s) of Service: _____

List ALL procedures requested along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting Medical Records)	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)

DO NOT WRITE BELOW THIS LINE — FOR CalOptima USE ONLY

STATUS		Authorization Number #:	
☐ Approved	☐ Alternative Treatment	Signature:	Date:
☐ Not a Covered Benefit	☐ Modified	Comments:	
☐ Not Medically Indicated	Affiliated Health Plan:	Phone:	

Revised 6/12/14

Back to Agenda

Print Form

CalOptima
A Public Agency
Better. Together.

Custom Wheelchair Evaluation Request

Information to accompany Clinical Questionnaire

Fax information to CalOptima at 714-481-6516

MEMBER INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____
(First) (MI) (Last)

Medi-Cal Number (CIN): _____ Gender: ☐ Female ☐ Male Phone: _____

Patient Address: _____ City: _____ ZIP: _____

☐ Home ☐ Board and Care ☐ ICF-DD SNF ☐ Other: _____

Facility Name: _____ Contact: _____

Language: Patient Speaks: _____ Patient Understands: _____

Caregiver / Family member participating in assessment and fitting ☐ YES ☐ NO ☐ N/A If yes, language spoken: _____

Transportation: ☐ Self / Family / Caregiver ☐ Public **OR** Medically necessary: ☐ Medivan ☐ Littervan ☐ Basic Ambulance

PRESCRIPTION

(Rx must be completed, signed, and dated by attending physician.)

Prescribing Physician _____

Medi-Cal Provider ID # _____

Phone: _____ Fax: _____

Address _____

Primary Care Physician (PCP): _____

Medi-Cal Provider ID # _____

Phone: _____ Fax: _____

Address _____

Primary Dx: _____ ICD-10: _____ Current Functional Status: _____

Current Wheelchair: ☐ YES ☐ NO If "YES": ☐ Manual ☐ Power ☐ Tilt/Recline Year: _____ Serial #: _____

Custom DME Prescribed: ☐ Therapeutic Cushion ☐ Manual Wheelchair ☐ Power Wheelchair ☐ Not Specified

M. D. Signature: _____ Date: _____

Preferred Vendor: _____

(If provider or member does not designate, CalOptima will assign DME vendor)

AUTHORIZATION *(For CalOptima Use Only)*

Eligibility Date: _____ Health Network: _____ Other Health Coverage: Medicare N/A

Utilization Contact: _____ Phone: _____ FAX: _____

Approved Codes:

- ☐ S100C & S200C (Therapeutic Seat Cushion and/or Positioning System & Post Delivery Assessment/Fitting)
- ☐ S101C & S201C (Custom Foam/Molded Cushion & Post Delivery Assessment Fitting)
- ☐ S 102C & S202C (Manual Wheelchair With or Without Therapeutic Cushion & Post Delivery
- ☐ S103C & S203C (Manual Wheelchair With Positioning System, With or Without Therapeutic Cushion & Post Delivery Assessment/Fitting
- ☐ S 104C & S204C (Power Wheelchair With or Without Therapeutic Cushion & Post Delivery
- ☐ AS105C & S205C t/Fitti) (Power Wheelchair With Power Tilt/Recline or Specialized Driving Controls & Post Delivery
- ☐ S300C & S301C (In-home assessment by DME Assessment Provider & Post Delivery Assessment/Fitting)

Approved Provider: _____

Authorization #: _____ Date Approved: _____ Date Sent: _____ By: Fax Mail

Records Attached: Progress Notes H&P Therapy Notes Operative Report Acute/LTC Facility Notes Previous Equipment Repairs

Denied M.D. Signature: _____ Date: _____

Back to Agenda

Print Form

CalOptima
Better. Together.

Clinical Questionnaire: Referring Physician Authorization for New Wheelchair and/or Custom Seating Equipment

Patient Name: Medi-Cal Number (CIN):

Thank you for taking the time to answer the following questions about your patient's need for new seating equipment. Your complete answers will ensure that your patient's authorization can be reviewed in a timely manner.

1. Please describe the patient's diagnosis and nature of injury:

2. Give a brief explanation of the patient's prognosis:

3. What is the patient's current functional status?

4. If you are prescribing a custom manual or power wheelchair, please give a brief explanation of why a standard manual wheelchair is not adequate for the patient's use:

5. If a power wheelchair is being requested, what is patient's current cognitive status?
   ☐ Not Alert ☐ Alert *Oriented to:* ☐ *Self* ☐ *Other* ☐ *Place* ☐ *Time*

6. If the patient is being evaluated for a custom seating system or therapeutic cushion, please explain why this is being requested.

7. Does the patient have a history of any skin breakdown? ☐ Yes ☐ No

8. List all the patient's relevant previous or pending surgeries:

9. If a new wheelchair, seating system or therapeutic cushion is being prescribed to replace existing equipment, please explain why the current equipment no longer meets the patient's needs.

10. What medical and functional objectives will be met with the equipment you have prescribed?

Additional relevant information:

Physician's Signature: _____ Date: _____

Please complete and return this form to:
CalOptima Care Coordination · P. O. Box 11033 · Orange, CA 92856 · Phone: (714) 246-8686 · FAX: (714) 481-6516

Back to Agenda

Print Form

CalOptima
Better Together.

WHEELCHAIR REPAIRS
Authorization Referral Form

Fax information to CalOptima at 714-481-6516

MEMBER INFORMATION

Patient Name:_____ Date of Birth:_____ Age:_____
(Last) (MI) (First)

Medi-Cal Number (CIN): _____ Gender: ☐ Female ☐ Male

Patient Address: _____ City: _____ Zip: _____ Phone: _____

☐ Home ☐ Board and Care ☐ ICF-DD ☐ SNF ☐ Other:_____

Facility Name: _____ Contact: _____

Language: Patient Speaks: _____ Patient Understands: _____

Caregiver / Family member participating in assessment and fitting ☐YES ☐ NO ☐ N/A If yes, language spoken: _____

PRESCRIPTION

(Rx must be completed, signed, and dated by attending physician.)

Prescribing Physician: _____

Medi-Cal Provider ID # _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip Code:_____

Primary Dx: _____ ICD-9: _____ Current Functional Status: _____

Current Wheelchair: ☐ Manual ☐ Power ☐ Tilt/Recline Year: _____ Serial #: _____

Brief description of services needed:

M. D. Signature: _____ License No: _____ Date: _____

PRINT Name: _____

CALOPTIMA TO ASSIGN DME VENDOR

Policy #:	GG.1535
Title:	**Utilization Review Criteria and Guidelines**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	08/01/05
Last Review Date:	~~01/01/18~~10/04/18
Last Revised Date:	~~01/01/18~~10/04/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy describes the process by which CalOptima ~~shall establish~~establishes Utilization ~~Review~~ criteria and guidelines to ensure that decisions related to Utilization Management and coverage or denial of organization determinations are made in a consistent manner and comport with ~~this policy~~program requirements and local and national care standards.

II. POLICY

A. CalOptima shall ensure that decisions related to Utilization Management (UM) and coverage or denial of requested Covered Services, and/or supplies, are consistent with the criteria and guidelines set forth in this policy.

~~B. On an annual basis, CalOptima shall administer Inter-Rater Reliability testing to all personnel who perform Organization Determinations and issue individual Corrective Action Plans (CAPs) to CalOptima staff who score below the acceptable threshold.~~

~~C.~~B. CalOptima shall not ~~specifically~~ reward Practitioners, or other individuals, for denying, limiting, or discontinuing coverage or care.

~~D.~~C. CalOptima shall ensure that criteria and practice guidelines and UM activities and decisions:

1. Are based on reasonable local and national medical evidence, or a consensus of health care professionals in the particular field;

2. Consider the needs of the enrolled population;

3. Are developed in consultation with contracted Providers; and

4. Are reviewed and updated annually, as appropriate, by submitting the recommended criteria and guidelines to the Utilization Management Committee (UMC) voting physician members for review and approval.

~~E.~~D. CalOptima shall conduct the Utilization Review using criteria and guidelines that are approved and adopted in the CalOptima UM Program. Such criteria and guidelines may include, but are not limited to:

1. Nationally ~~-~~recognized Evidence Based criteria such as Milliman Care Guidelines (MCG);

~~2.~~ Medicare and Medi-Cal ~~coverage guidelines and criteria;~~

~~3.~~1. ~~National Comprehensive Cancer Network (NCCN) Guidelines;~~

~~4.~~2. ~~CalOptima proprietary Level~~Manual of ~~Care criteria for outpatient services~~Criteria;

~~5. Specialty society guidelines, such as American Academy of Pediatrics (AAP);~~

~~6.~~3. Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) guidelines;

4. Medicare Part D: CMS-approved Compendia;

5. National Guideline Clearinghouse;

6. National Comprehensive Cancer Network (NCCN) Guidelines;

7. Transplant Centers of Excellence guidelines;

8. Specialty society guidelines, such as American Academy of Pediatrics (AAP) and American Heart Association (AHA) Guidelines;

~~8.~~9. Preventive health guidelines (~~i.~~*e.g.*, U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG~~)~~ Guidelines);

~~9.~~10. CalOptima Criteria for outpatient behavioral health ~~Level of Care guidelines for outpatient~~ services~~; and~~,

~~10.~~11. CalOptima Policies and Medi-Cal Benefits Guidelines~~.~~, and

12. Effective January 1, 2019, active CCS Numbered Letters (N.L.s) and CCS Information Notices applicable to County Organized Health System Plans in the WCM program~~.~~.

D. If CalOptima delegates Utilization Review, in accordance with CalOptima Policy GG.1541: Utilization Management Delegation, the Delegate shall submit its Utilization Review criteria and guidelines to CalOptima for approval prior to implementation.

E. Upon a treating physician's or Member's request, CalOptima~~,~~ or the Member's Health Network shall provide, in writing, all criteria used in making a UM ~~decisions~~decision including, but not limited to, discharge and continued stay criteria, and clinical practice guidelines.

~~F. On an annual basis, CalOptima and its Health Networks shall audit all staff who make UM decisions for Inter-Rater Reliability to verify the consistent and accurate application of Utilization Review criteria in decision-making.~~

~~G.~~F. CalOptima shall ensure its UM policies, processes, strategies, evidentiary standards, and other factors used for UM or utilization review are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.

III. PROCEDURE

A. CalOptima shall document Utilization Review criteria and guidelines utilized for ~~Organization Determinations~~decisions related to Utilization Management and coverage or denial of requested services.

B. CalOptima shall automatically incorporate all Medicare and Medi-Cal changes into its Utilization Review criteria and guidelines, no later than the effective date of the ~~changes~~change and will seek UMC approval at the next regularly scheduled UMC meeting.

C. On an annual basis, CalOptima's Director of Utilization Management or Designee shall submit criteria and guidelines, as specified in Section ~~III.E~~II.D. of this policy, to the ~~Utilization Management Committee (~~UMC~~)~~ and Quality Improvement Committee (QIC) for review and approval.

D. Upon the QIC's approval of the criteria and guidelines, the CalOptima's Director of Utilization Management or Designee shall adopt and implement the approved criteria into the UM Program.

E. Upon the UM Committee's and QIC's approval of the criteria and guidelines, CalOptima shall:

1. Distribute the criteria and guidelines to all of CalOptima's professional reviewers;

2. Activate the criteria and guidelines in the UM systems; and

3. Make the criteria and guidelines available to Members and Providers, upon request.

F. Delegated Health Networks shall, pursuant to the CalOptima Health Network Service Agreement, adopt and implement Evidence-Based criteria and guidelines related to utilization Organization Determinations. The CalOptima Audit and Oversight Department shall monitor and ensure this requirement is reviewed annually by the Delegate's Utilization Management Committee for all CalOptima programs.

G. ~~On an annual basis, CalOptima's Director of Utilization Management or Designee shall conduct~~ Inter-~~Rater~~Rate Reliability Audits

1. On an annual basis, CalOptima and its Health Networks shall audit all staff who make UM decisions for Inter-Rater Reliability to verify the consistent and accurate application of Utilization Review criteria in decision-making.~~audits on professional reviewers.~~

~~G.~~2. CalOptima's Director of Utilization Management or Designee shall forward results of the CalOptima Inter-Rater Reliability audits to the ~~UM Committee~~UMC for review and action.

3. CalOptima shall issue individual Corrective Action Plans (CAPs) to CalOptima staff who score below the acceptable threshold.

H. If the CalOptima Medical Director identifies a need to update any criteria or guidelines, CalOptima's Director of Utilization Management or Designee shall submit a request to the ~~QIC~~UMC to implement such update~~.~~; updates approved by the UMC will be presented to the next regularly scheduled QIC for final review and approval

I. CalOptima shall monitor a Delegate's UM activities including the Delegate's use of CalOptima's criteria and guidelines, in accordance with CalOptima Policy GG.1541: Utilization Management Delegation.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~C.~~A. ~~CalOptima Health Network Service Agreement~~
~~D.~~A. ~~CalOptima Policy GG.1541: Utilization Management Delegation~~
~~E.~~C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Health Network Service Agreement
E. CalOptima Policy GG.1541: Utilization Management Delegation
F. CalOptima Utilization Management Program
G. Medicare and Medi-Cal Coverage Guidelines
H. Health and Safety Code Sections, 1363.5 and 1367.01
I. Title 42, Code of Federal Regulations, Section 438.910(d)
J. Department of Health Care Services (DHCS) All Plan Letter 18-011: California Children's Services Whole Child Model Program
K. California Children's Services Numbered Letter Index

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

~~None to Date~~A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/01/2005	MA.6001	Utilization Review Criteria and Guidelines	OneCare
Revised	01/01/2007	MA.6001	Utilization Review Criteria and Guidelines	OneCare
Revised	06/01/2013	MA.6001	Utilization Review Criteria and Guidelines	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	11/01/2015	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Retired	12/22/2015	MA.6001	Utilization Review Criteria and Guidelines	OneCare
Revised	10/01/2016	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Revised	11/01/2017	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Revised	01/01/2018	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Revised	10/04/2018	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
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, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. One Care 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 and Centers for Medicare & Medicaid Services (CMS).
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.
Evidence-Based	A document or recommendation created using an unbiased and transparent process of systematically reviewing, appraising, and using the best clinical research findings of the highest value to aid in the delivery of optimum clinical care to patients.
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), Physician Medical Group (PMG), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Inter-Rater Reliability	An assessment tool that measures the degree of reliability of different licensed staff when utilizing criteria for authorizing or denying Covered Services.
Member	An enrollee-beneficiary of a CalOptima program.

Term	Definition
Organization Determination	Medi-Cal: Any decision made by an entity regarding receipt of, or payment for, a managed care item or service, the amount that the entity requires a Member to pay for an item or service, or a limit on the quality of items or service. OneCare and OneCare Connect: Any determination made by OneCare or OneCare Connect with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider other than OneCare or OneCare Connect that the Member believes: a. Are covered under Medicare; or ~~a.~~ ~~2.~~b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by OneCare or OneCare Connect. 3. OneCare or OneCare Connect's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by OneCare or OneCare Connect; 4. Discontinuation of a service if the Member believes that continuation of the service is medically necessary; and 5. OneCare or OneCare Connect's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.
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.
Utilization Management (UM) Program	A written document evaluated and revised on an annual basis, that describes the Utilization Management policies, procedures, processes, programs that are implemented organizationally to attain goals set forth by the health plan, to meet health plan, State, Federal, and accrediting agency requirements.
Utilization Review	Process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities.

Policy #:	GG.1535
Title:	**Utilization Review Criteria and Guidelines**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	08/01/05
Last Review Date:	10/04/18
Last Revised Date:	10/04/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy describes the process by which CalOptima establishes Utilization criteria and guidelines to ensure that decisions related to Utilization Management and coverage or denial of organization determinations are made in a consistent manner and comport with program requirements and local and national care standards.

II. POLICY

A. CalOptima shall ensure that decisions related to Utilization Management (UM) and coverage or denial of requested Covered Services, and/or supplies, are consistent with the criteria and guidelines set forth in this policy.

B. CalOptima shall not reward Practitioners, or other individuals, for denying, limiting, or discontinuing coverage or care.

C. CalOptima shall ensure that criteria and practice guidelines and UM activities and decisions:

1. Are based on reasonable local and national medical evidence, or a consensus of health care professionals in the particular field;

2. Consider the needs of the enrolled population;

3. Are developed in consultation with contracted Providers; and

4. Are reviewed and updated annually, as appropriate, by submitting the recommended criteria and guidelines to the Utilization Management Committee (UMC) voting physician members for review and approval.

D. CalOptima shall conduct the Utilization Review using criteria and guidelines that are approved and adopted in the CalOptima UM Program. Such criteria and guidelines may include, but are not limited to:

1. Nationally-recognized Evidence Based criteria such as Milliman Care Guidelines (MCG);

2. Medicare and Medi-Cal Manual of Criteria;

3. Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) guidelines;

4. Medicare Part D: CMS-approved Compendia;

5. National Guideline Clearinghouse;

6. National Comprehensive Cancer Network (NCCN) Guidelines;

7. Transplant Centers of Excellence guidelines;

8. Specialty society guidelines, such as American Academy of Pediatrics (AAP) and American Heart Association (AHA) Guidelines;

9. Preventive health guidelines (*e.g.*, U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG Guidelines);

10. CalOptima Criteria for outpatient behavioral health services,

11. CalOptima Policies and Medi-Cal Benefits Guidelines, and

12. Effective January 1, 2019, active CCS Numbered Letters (N.L.s) and CCS Information Notices applicable to County Organized Health System Plans in the WCM program.

D. If CalOptima delegates Utilization Review, in accordance with CalOptima Policy GG.1541: Utilization Management Delegation, the Delegate shall submit its Utilization Review criteria and guidelines to CalOptima for approval prior to implementation.

E. Upon a treating physician's or Member's request, CalOptima or the Member's Health Network shall provide, in writing, all criteria used in making a UM decision including, but not limited to, discharge and continued stay criteria, and clinical practice guidelines.

F. CalOptima shall ensure its UM policies, processes, strategies, evidentiary standards, and other factors used for UM or utilization review are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.

III. PROCEDURE

A. CalOptima shall document Utilization Review criteria and guidelines utilized for decisions related to Utilization Management and coverage or denial of requested services.

B. CalOptima shall automatically incorporate all Medicare and Medi-Cal changes into its Utilization Review criteria and guidelines, no later than the effective date of the change and will seek UMC approval at the next regularly scheduled UMC meeting.

C. On an annual basis, CalOptima's Director of Utilization Management or Designee shall submit criteria and guidelines, as specified in Section II.D. of this policy, to the UMC and Quality Improvement Committee (QIC) for review and approval.

D. Upon the QIC's approval of the criteria and guidelines, the CalOptima's Director of Utilization Management or Designee shall adopt and implement the approved criteria into the UM Program.

E. Upon the UM Committee's and QIC's approval of the criteria and guidelines, CalOptima shall:

1. Distribute the criteria and guidelines to all of CalOptima's professional reviewers;

2. Activate the criteria and guidelines in the UM systems; and

3. Make the criteria and guidelines available to Members and Providers, upon request.

F. Delegated Health Networks shall, pursuant to the CalOptima Health Network Service Agreement, adopt and implement Evidence-Based criteria and guidelines related to utilization Organization Determinations. The CalOptima Audit and Oversight Department shall monitor and ensure this requirement is reviewed annually by the Delegate's Utilization Management Committee for all CalOptima programs.

G. Inter-Rate Reliability Audits

1. On an annual basis, CalOptima and its Health Networks shall audit all staff who make UM decisions for Inter-Rater Reliability to verify the consistent and accurate application of Utilization Review criteria in decision-making.

2. CalOptima's Director of Utilization Management or Designee shall forward results of the CalOptima Inter-Rater Reliability audits to the UMC for review and action.

3. CalOptima shall issue individual Corrective Action Plans (CAPs) to CalOptima staff who score below the acceptable threshold.

H. If the CalOptima Medical Director identifies a need to update any criteria or guidelines, CalOptima's Director of Utilization Management or Designee shall submit a request to the UMC to implement such update; updates approved by the UMC will be presented to the next regularly scheduled QIC for final review and approval

I. CalOptima shall monitor a Delegate's UM activities including the Delegate's use of CalOptima's criteria and guidelines, in accordance with CalOptima Policy GG.1541: Utilization Management Delegation.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Health Network Service Agreement
E. CalOptima Policy GG.1541: Utilization Management Delegation
F. CalOptima Utilization Management Program
G. Medicare and Medi-Cal Coverage Guidelines
H. Health and Safety Code Sections, 1363.5 and 1367.01

I. Title 42, Code of Federal Regulations, Section 438.910(d)
J. Department of Health Care Services (DHCS) All Plan Letter 18-011: California Children's Services Whole Child Model Program
K. California Children's Services Numbered Letter Index

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/01/2005	MA.6001	Utilization Review Criteria and Guidelines	OneCare
Revised	01/01/2007	MA.6001	Utilization Review Criteria and Guidelines	OneCare
Revised	06/01/2013	MA.6001	Utilization Review Criteria and Guidelines	OneCare
Revised	11/01/2015	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Retired	12/22/2015	MA.6001	Utilization Review Criteria and Guidelines	OneCare
Revised	10/01/2016	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Revised	11/01/2017	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Revised	01/01/2018	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Revised	10/04/2018	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
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, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. One Care 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 and Centers for Medicare & Medicaid Services (CMS).
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.
Evidence-Based	A document or recommendation created using an unbiased and transparent process of systematically reviewing, appraising, and using the best clinical research findings of the highest value to aid in the delivery of optimum clinical care to patients.
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), Physician Medical Group (PMG), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Inter-Rater Reliability	An assessment tool that measures the degree of reliability of different licensed staff when utilizing criteria for authorizing or denying Covered Services.
Member	An enrollee-beneficiary of a CalOptima program.

Term	Definition
Organization Determination	Medi-Cal: Any decision made by an entity regarding receipt of, or payment for, a managed care item or service, the amount that the entity requires a Member to pay for an item or service, or a limit on the quality of items or service. OneCare and OneCare Connect: Any determination made by OneCare or OneCare Connect with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider other than OneCare or OneCare Connect that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by OneCare or OneCare Connect. 3. OneCare or OneCare Connect's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by OneCare or OneCare Connect; 4. Discontinuation of a service if the Member believes that continuation of the service is medically necessary; and 5. OneCare or OneCare Connect's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.
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.
Utilization Management (UM) Program	A written document evaluated and revised on an annual basis, that describes the Utilization Management policies, procedures, processes, programs that are implemented organizationally to attain goals set forth by the health plan, to meet health plan, State, Federal, and accrediting agency requirements.
Utilization Review	Process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities.

1

Policy #: GG.1547PP
Title: **Maintenance and Transportation**
Department: Medical Affairs
Section: Case Management

CEO Approval: Michael Schrader _____

Effective Date: 01/01/19
Last Review Date: Not Applicable
Last Revised Date: Not Applicable

I. PURPOSE

This policy defines the criteria and process for administration of the Maintenance and Transportation benefit for CalOptima Members eligible with the California Children's Services (CCS) Program.

II. POLICY

A. CalOptima is responsible for authorizing and reimbursing Maintenance and Transportation for CCS-eligible Members enrolled in CalOptima Direct and the Health Networks. The Health Networks shall be responsible for identifying CCS-eligible Members that may be eligible for the Maintenance and Transportation benefit and forward the necessary information to CalOptima to determine benefit eligibility.

B. CalOptima shall provide Maintenance and Transportation benefits to CalOptima CCS-eligible Members or such Member's family seeking transportation to a Covered Service related to their CCS-Eligible Condition when the cost of Maintenance and Transportation presents a barrier to accessing authorized diagnostic or treatment services.

C. CalOptima may authorize Maintenance and Transportation when CalOptima determines:

1. No other available resources exist to assist the CCS-eligible Member/parent(s)/legal guardian(s) to access authorized Medically Necessary medical services related to the Member's CCS-Eligible Condition, including:

   a. The Member, parent(s)/legal guardian(s) have no means of reaching the approved provider/facility without outside help; and

   b. Alternative resources for these services are not available in the community

D. A Health Network shall coordinate with the CalOptima Case Management Department to ensure timely and appropriate delivery of Maintenance and Transportation services in accordance with Section III.B. of this Policy.

E. Transportation

1. CalOptima will arrange the most appropriate and cost-effective mode of transportation to access authorized medical services. If the CCS-eligible Member and/or parent(s)/legal guardian(s) choose to go to a provider/facility that is not the closest CCS approved facility/paneled provider, transportation costs beyond those to reach the closest provider capable of delivering

the level/type of services required are the responsibility of the Member and/or parent(s)/legal guardian(s).

F. Non-Emergency Medical Transportation (NEMT) is not covered under the Maintenance and Transportation benefit. NEMT is provided in accordance with CalOptima Policy GG.1505: Transportation: Emergency, Non-emergency and Non-medical.

G. CalOptima may approve Transportation to a Medical Therapy Unit (MTU) for physical or occupational therapy, or to attend a Medical Therapy Conference if a transportation need has been identified jointly by the family and the MTU treating therapist as necessary for the CCS-eligible Member's access to these services in accordance with the provisions of this Policy and when transportation is not included in the Member's Individualized Education Plan (IEP).

H. Maintenance and Transportation may be a benefit for authorized medical care provided outside the state of California for a CCS-eligible condition in accordance with the provisions of this Policy.

I. A Member, family or legal guardian may appeal a denial for Maintenance and Transportation assistance in accordance with CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services.

III. PROCEDURE

A. A Health Network shall identify a CCS-eligible Member who may be eligible for the Maintenance and Transportation benefit through communication with the Member, family or legal guardian and confirmation of an approved treatment request meeting the criteria in this Policy.

B. The Health Network shall forward the following information to CalOptima via fax or other secure method:

1. Completed WCM Maintenance and Transportation Assistance Worksheet;

2. Approval notification for the Medically Necessary diagnostic and/or treatment services for the CCS-Eligible Condition for which Maintenance and Transportation is requested; and

3. Name and contact number for Health Network case manager.

4. The CalOptima case management transportation coordinator shall review the Maintenance and Transportation request and documentation submitted.

   a. If the request meets the requirements for Maintenance and Transportation assistance, as outlined in this Policy, CalOptima shall send notification of approval to the WCM Member/family or legal guardian and the Member's Health Network.

      i. CalOptima shall coordinate with CalOptima's transportation vendor Special Arrangements Liaison to ensure approved Maintenance and Transportation arrangements are made, either prospectively or for reimbursement of allowable expenses incurred by the CCS-eligible Member, family or legal guardian.

      ii. CalOptima shall be responsible to pay approved Maintenance and Transportation costs to the contracted vendor.

b. If the request does not meet the requirements for Maintenance and Transportation assistance as outlined in this Policy, CalOptima shall issue a Notice of Action (NOA)/Notice of Adverse Benefit Determination (NABD) to the CCS-eligible Member, family or legal guardian and provide a copy of the notice to the Health Network.

i. The Health Network case manager shall work with the WCM Member, family or legal guardian to provide alternative resources.

C. CalOptima shall identify CCS-eligible Members assigned to CalOptima Direct who may be eligible for the Maintenance and Transportation benefit through communication with the CCS-eligible Member, family or legal guardian and approval for treatment request meeting the criteria in this Policy.

1. The assigned CalOptima case manager shall complete the WCM Maintenance and Transportation Assistance Worksheet, attach the document in the medical management system and send a request for action in the medical management system to the CalOptima case management transportation coordinator.

2. The CalOptima case management transportation coordinator shall review the Maintenance and Transportation request and documentation submitted.

a. If the request meets the requirements for Maintenance and Transportation assistance as outlined in this Policy, notification of approval will be sent to the Member/family or legal guardian and a request for action will be sent to the assigned Case Manager.

i. CalOptima shall coordinate with CalOptima's transportation vendor Special Arrangements Liaison to ensure approved Maintenance and Transportation arrangements are made, either prospectively or for reimbursement of allowable expenses incurred by the CCS-eligible Member, family or legal guardian.

b. If the request does not meet the requirements for Maintenance and Transportation assistance as outlined in this Policy, CalOptima shall issue a NOA/NABD to the Member, family or legal guardian.

i. The assigned case manager shall work with the WCM Member, family or legal guardian to provide alternative resources.

D. CalOptima may authorize Maintenance when:

1. The CCS-eligible Member is obtaining authorized outpatient services and the distance from the CCS-eligible Member's home to the facility/provider authorized for outpatient services is such that the trip cannot be made in one (1) calendar day; or

2. If the parent(s)/legal guardian(s) are staying with and supporting a hospitalized CCS-eligible Member and the distance from the Member's home to the facility is such that the trip cannot be made in one (1) calendar day; and

3. Alternative resources have been explored and are unavailable; and

4. The CCS-eligible Member and/or parent(s)/legal guardian(s) have no means of providing for their Maintenance without the assistance from CalOptima.

5. CalOptima shall not reimburse a family for meals and lodging if the family could make the trip in one (1) calendar day if they had traveled to the nearest appropriate provider for services.

E. Access to Inpatient Services

1. Maintenance

a. For intensive care settings, when the parent/legal guardian is not permitted to stay at the CCS-eligible Member's bedside, CalOptima may initially authorize up to seven (7) calendar days of lodging and meals per hospitalization for one (1) or two (2) parent(s)/legal guardian(s). CalOptima will evaluate the need for additional lodging and meals based on the Member's circumstances.

b. For non-intensive care settings when parent(s)/legal guardian(s) are able to stay at the CCS-eligible Member's bedside, CalOptima may authorize one (1) calendar day of lodging for one (1) or two (2) parent(s)/legal guardian(s) after every six (6) nights of Member hospitalization.

c. CalOptima may authorize the total maximum Maintenance and Transportation authorization when a CCS-eligible Member is in intensive or non-intensive care setting shall be fifteen (15) calendar days of lodging and associated meals for each thirty (30) calendar days of Member hospitalization, beginning with the day of the Member's admission. Each new Member hospitalization shall be a new thirty (30) calendar day Maintenance and Transportation benefit period.

2. Transportation

a. Two (2) round trips per CCS-eligible Member's hospitalization for stays of less than seven (7) calendar days duration.

b. One (1) round trip for every seven (7) calendar days of a CCS-eligible Member's hospitalization in addition to the initial two (2) trips, if the hospitalization lasts longer than seven (7) calendar days.

3. Post-hospitalization

a. CalOptima may authorize lodging and meals for a Member and the Member's parent or guardian if the Member's discharge plan documents the need for daily medical visits for treatment of the CCS-Eligible Condition, and the distance precludes making the trip to the hospital in one (1) calendar day.

F. Access to Outpatient Services

1. Maintenance

a. If a family's trip to the outpatient provider can be completed in one (1) calendar day (round trip travel and appointment time included), there should not be reimbursement for meals or lodging.

b. If the total time for the trip will exceed one (1) calendar day, lodging and meals for one (1) or two (2) parents/legal guardian(s) and the CCS-eligible Member may be authorized.

2. Transportation

a. If the distance to the provider is such that the trip may be made in one (1) calendar day, then the family may be assisted with Transportation if lack of transportation is a barrier to the family's compliance with the treatment plan.

b. CalOptima may provide approval for a block of multiple trips when it is known that a CCS-eligible Member must make a specified number of visits to the provider for treatment, such as radiation therapy, chemotherapy, etc.

G. Reimbursement

1. Private Car Mileage: Reimbursement will be at the Internal Revenue Service (IRS) standard mileage rate for medical transportation. The rate paid will be the rate in effect on the date the travel occurred, not the rate in effect at the time the claim is submitted for payment.

2. Lodging costs for Member/parent(s)/ legal guardian(s): Reimbursement shall be based on the usual or actual costs of one (1) room up to the maximum amount per night based on the State of California employee lodging. Reimbursement for the cost of lodging provided by facilities sponsored by charitable organizations should not be greater than the customary charges to families.

3. Meals: Reimbursement shall be at actual costs per person, up to $15/day. Hospital meal voucher(s) will be credited as part of the $15/day meal assistance. Reimbursement will be based on actual costs supported by receipts for meals. Hospital meal vouchers provided to the Member/parent(s)/legal guardian(s) will be paid based upon the invoice submitted by the hospital.

4. Other necessary expenses: Reimbursement may be made for other necessary expenses, including, but not limited to, parking and tolls based upon actual costs supported by receipts.

5. CalOptima shall inform CCS-eligible Members or parent(s)/legal guardian(s), in writing, of the following, upon approval of the Maintenance and Transportation request:

a. How to submit requests for reimbursement;

b. How to submit required receipts and/or other documentation for expenses incurred as Maintenance and Transportation (gasoline, hotel/motel, meals, parking, tolls, etc.); and

c. That failure to comply with these requirements could preclude future authorization of Maintenance and Transportation services for the Member/family

H. CalOptima shall maintain a record of authorizations for Maintenance and Transportation services, which includes:

1. Start and end dates of authorization for Maintenance and/or Transportation services;

2. Member name;

3. Member Client Index Number (CIN);

4. CCS number;

5. Type and number of authorized services; and

6. Vendor contact information.

IV. ATTACHMENTS

A. WCM Maintenance and Transportation Assistance Worksheet

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Department of Health Care Services (DHCS) All Plan Letter 18-011: California Children's Services Whole Child Model Program
C. CCS Numbered Letter 03-0810: Maintenance and Transportation for CCS Clients to Support Access to CCS Authorized Medical Services
D. CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency & Non-Medical
E. CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services
F. California Health and Safety Code, §123840(j)
G. U.S. Code Title 26, Subtitle A, Chapter 1, Subchapter B, Part VII, §213

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2019	GG.1547PP	Maintenance and Transportation	Medi-Cal

IX. GLOSSARY

Term	Definition
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services-Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
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.
Health Network	A Physician Hospital Consortium (PHC), physician medical group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network
Maintenance	The cost(s) for lodging (such as motel room, etc.) and food for the Member, parent(s), or legal guardian(s) when needed to enable the Member to access authorized services for a CCS-Eligible Condition.
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.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Non-Emergency Medical Transportation	Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.
Transportation	For purposes of this Policy, the cost(s) for the use of a private vehicle or public conveyance to provide the Member access to authorized services.

Medi-Cal CalOptima A Public Agency Better. Together.

WCM Maintenance and Transportation Assistance Worksheet

Member Name _____ CIN: _____

Member/Family current address: _____

CCS-Eligible Dx: _____

M&T requested by: ☐ Member ☐ Parent/guardian ☐ Other

Local CCS Provider: _____

Treating Provider/Facility (for treatment requiring M&T) _____

Contact: _____

Address: _____ Phone: _____

Assistance requested:

☐ Lodging: Date(s): _____ ☐ Meals: Date(s): _____

☐ Transportation(**only** non-NEMT): ☐Bus ☐Train ☐Private car ☐Taxi ☐Other _____

☐ Other Transportation Costs: _____

Notes:(Information about treatment needing M&T support- inpatient ICU/other, anticipated length of stay, outpatient treatment)

_____

_____

_____

Alternative resources reviewed with member/family/legal guardian (HN attestation):

☐ Family, friends, faith institution

☐ Alternative appointment schedule/location to minimize need for M&T

For CalOptima Use Only

Services Approved and coordinated with vendor:

☐ Lodging: Facility: _____
Dates of stay: _____
Total # of lodging nights: _____

☐ Meals: Ttl $_____

☐ Transportation: Details: _____

☐ Other Transportation Costs: Ttl $_____

☐ Approval notification sent: date _____

Services Denied: _____

Reason for denial: _____ ☐ NOA sent: date _____

Version 8/8/18

Back to Agenda

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: January 19, 2018

ALL PLAN LETTER 17-020 *(REVISED)*

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: AMERICAN INDIAN HEALTH PROGRAMS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding reimbursement for American Indian Health Programs (Exhibit A, Attachment 8 of the MCP's contract). The Department of Health Care Services (DHCS) has developed a change in policy regarding reimbursement of American Indian Health Programs providing services to Medi-Cal managed care beneficiaries. *Revised text is found in italics.*

BACKGROUND:

Under federal law, California must ensure that American Indian Health Programs are paid the applicable encounter *rate* published annually in the Federal Register by the Indian Health Service (the Office of Management and Budget (OMB) encounter *rate*), and if there is any difference between the amount paid by an MCP and the applicable OMB encounter rate, the State is required to make an additional payment pursuant to Title 42 of the United States Code (USC) Section 1396u-2(h)(2)(C)(ii)[1] and Title 42 of the Code of Federal Regulations (CFR) Sections 438.14(c)(2) and (3).[2]

Historically, the State satisfied this requirement by tracking the amounts American Indian Health Programs received from MCPs for eligible services and by making subsequent payments necessary to meet the applicable OMB encounter rate.

[1] 42 USC Section 1396u-2(h)(2)(C)(ii) is available at: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section1396u-2&num=0&edition=prelim

[2] 42 CFR Sections 438.14(c)(2) and (3) are available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=38cdce7f77ce8077ee8d0d1b41735ffa&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_114

Under the policy change addressed in this APL, the State will now require that MCPs *make the necessary payments* to American Indian Health Programs *so that they receive the applicable OMB encounter rate* for eligible services provided on or after January 1, 2018.

POLICY:

Effective January 1, 2018, MCPs are required to *make the payments described below, so that* American Indian Health Programs for eligible services provided on or after January 1, 2018, at the applicable OMB encounter rate, published in the Federal Register by the Indian Health Service.

MCPs are reminded of their obligations to attempt to contract with American Indian Health Programs, prompt payment requirements, and the allowance for non-contracted American Indian Health Programs access, where applicable.

Office of Management and Budget Encounter Rate and Services:

Where the OMB encounter *rate applies, American Indian Health Programs must be paid as follows:*

1) *For* Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, the *required payment is the difference between* the "Outpatient Per Visit Rate (Excluding Medicare)" *listed in the Federal Register and 80 percent of the Medicare Federally Qualified Health Center (FQHC) prospective payment system (PPS) rate, as set forth in 42 USC 1395w-4(e)(6)(A)(ii). See Attachment 2 for the specific Dual rate.*

2) *For* Medi-Cal *beneficiaries that do* not have Medicare *Coverage* or *have* Medicare Part A only*, the required payment is the "Outpatient Per Visit Rate (Excluding Medicare)". See Attachment 2 for the specific Non-Dual rate.*

The service types—medical visits, ambulatory visits, and mental health visits— for which the OMB encounter *rate applies* are set forth in the California Medicaid State Plan Supplement 6, Attachment 4.19-B.[3] The service types reimbursed at the OMB

[3] The *relevant State Plan Amendment* is available at: http://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supplement6toAttachment4.19-B-REVISEDMAY.pdf

encounter rate are further detailed in the Provider Manual.[4] To the extent that the Provider Manual conflicts with this APL, the requirements of this APL shall apply. Exceptions to MCP covered services that shall continue to be reimbursed outside the OMB encounter rate are: Non-Medical Transportation, Non-Emergency Medical Transportation, and Pharmacy.

Additionally, this policy does not extend the responsibility of the MCP to provide for eligible OMB encounter services that are outside the responsibility of the MCP currently. For example, MCPs will not be responsible for reimbursing the clinics for any dental services provided. The American Indian Health Programs will continue to follow their current billing practices for services outside the MCP's responsibility.

The OMB encounter rates are historically published with a retroactive effective date. MCPs are required to pay the most current applicable *payments as described in this APL (see Attachment 2)* during the calendar year for which the rate applies, and as an interim rate in a subsequent calendar year if an updated OMB rate has not been published. Plans shall ensure interim payments are reconciled to the applicable updated OMB rate for that calendar year in accordance with contractual prompt payment requirements.

Reimbursement Requirements:

MCPs shall ensure that the following criteria are met for receipt of *payments as described in this APL*:

- The American Indian Health Program provider must be identified by DHCS (see Attachment).
- Service must be a covered benefit included in the MCP's contract with DHCS.
- As set forth in California Medicaid State Plan Supplement 6, Attachment 4.19-B, only one OMB encounter rate payment per day, per category, shall be allowed within the following three categories. This allows for a maximum of three OMB encounter payments per day, one from each category:

[4] The Provider Manual sections related to IHS are available at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/indhealth_o01o03.doc

- Medical Health Visit (Encounter) – A medical visit is a face-to-face encounter occurring at a clinic or center between a American Indian Health Program recipient and physician, physician assistant, nurse practitioner, nurse midwife or visiting nurse in certain circumstances.

- Mental Health Visit (Encounter) – A mental health visit is a face-to-face encounter between an American Indian Health Program recipient and a psychiatrist, clinical psychologist, clinical social worker, or other health professional for therapeutic mental health services.

- Ambulatory Visit (Encounter) – An ambulatory visit is a face-to-face encounter between an American Indian Health Program recipient and a health care professional other than a physician or mid-level practitioner which is included in California's Medi-Cal State Plan.

Monitoring of Subcontractors and Delegated Entities:

MCPs remain ultimately responsible for meeting the American Indian Service Programs reimbursement requirements, and must ensure that their delegated entities and subcontractors comply with all applicable State and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance and All Plan Letters (APLs). MCPs must communicate these requirements to all delegated entities and subcontractors in a timely manner to ensure compliance.

If you have any questions regarding this APL, and/or requests for an approved list of American Indian Service Programs, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachments

Back to Agenda

APL 17-020
Attachment #1 : List of American Indian Health Program Providers*
Last Updated: 8-7-18

NPI	LEGAL NAME	ADDRESS	CITY	COUNTY	EFFECTIVE DATE	DEACTIVATION DATE
1366519431	MACT HEALTH BOARD, INC -JACKSON RANCHERIA HEALTH	12140 NEW YORK RANCH RD	JACKSON	AMADOR	09/01/2002	
1629130240	FEATHER RIVER TRIBAL HEALTH	2145 5TH AVE	OROVILLE	BUTTE	09/01/2002	
1740634286	NORTHERN VALLEY INDIAN HEALTH INC	500 COHASSET RD STE 15	CHICO	BUTTE	05/16/2016	
1770859084	NORTHERN VALLEY INDIAN HEALTH INCORPORATED	1515 SPRINGFIELD DRIVE, STE 175	CHICO	BUTTE	12/11/2012	
1265567127	NORTHERN VALLEY INDIAN HEALTH, INC	845 W. EAST AVENUE	CHICO	BUTTE	09/01/2002	
1346410255	MACT HEALTH BOARD INC	1113 HWY 49	SAN ANDREAS	CALAVARES	03/17/2009	
1366159431	MACT HEALTH BOARD, INC	1113A HWY 49	SAN ANDREAS	CALAVARES	05/05/2017	
1790778660	COLUSA INDIAN COMMUNITY COLUSA INDIAN HEALTH CLN	3710 HIGHWAY 45	COLUSA	COLUSA	08/09/2002	
1821440371	UNITED INDIAN HEALTH SERVICES INC	501 NORTH INDIAN RD	SMITH RIVER	DEL NORTE	06/12/2017	
1043216021	UNITED INDIAN HEALTH SERVICS INC	1675 NORTHCREST DR	CRESCENT CITY	DEL NORTE	09/01/2002	

‡ Address Change
‡‡Effective Date Change
*Alphabetical by County

NPI	LEGAL NAME	ADDRESS	CITY	COUNTY	EFFECTIVE DATE	DEACTIVATION DATE
1821440371	UNITED INDIAN HEALTH SERVICES INC ‡	241 SALMON AVENUE	KLAMATH	DEL NORTE	6/12/2017	
1245356674	SHINGLE SPRINGS TRIBAL HEALTH PROGRAM	4140 MOTHER LODE DR	SHINGLE SPRINGS	EL DORADO	09/01/2002	
1275751257	CENTRAL VALLEY INDIAN HEALTH INC	2740 HERNDON	CLOVIS	FRESNO	09/01/2002	
1235670787	CENTRAL VALLEY INDIAN HEALTH INC	255 W BULLARD AVENUE STE 109	CLOVIS	FRESNO	08/14/2017	
1902025059	CENTRAL VALLEY INDIAN HEALTH-PRATHER	29369 AUBERRY ROAD SUITE 102	PRATHER	FRESNO	09/01/2002	
1295752384	NORTHERN VALLEY INDIAN HEALTH	207 N. BUTTE STREET	WILLOWS	GLENN	09/01/2002	
1386726032	KARUK TRIBE	325 ASIP ROAD	ORLEANS	HUMBOLDT	09/01/2002	
1306904222	K'IMA: W MEDICAL CENTER	POST OFFICE BOX 1288	HOOPA	HUMBOLDT	09/01/2002	
1497751572	UNITED INDIAN HEALTH SVS EUREKA	1600 WEEOT WAY	ARCATA	HUMBOLDT	09/01/2002	
1497751572	UNITED INDIAN HEALTH SVS	940 MAIN STREET	FORTUNA	HUMBOLDT	09/01/2002	
1497751572	UNITED INDIAN HEALTH SVS	HWY 96	WEITCHPEC	HUMBOLDT	09/01/2002	
1265719918	DHHS PHS IHS PHOENIX AREA	ONE INDIAN HILL RD	WINTERHAVEN	IMPERIAL	11/17/2011	

‡ Address Change
‡‡Effective Date Change
*Alphabetical by County

Back to Agenda

NPI	LEGAL NAME	ADDRESS	CITY	COUNTY	EFFECTIVE DATE	DEACTIVATION DATE
1659433191	TOIYABE INDIAN HLTH PROJ - BISHOP CLINIC	250 N SEE VEE LANE	BISHOP	INYO	11/01/1991	
1205950888	TOIYABE INDIAN HLTH PROJ - LONE PINE CLINIC	1150 GOODWIN RD	LONE PINE	INYO	01/15/2008	
1215157375	CENTRAL VLY INDIAN HLTH TACHI MEDICAL CENTER	16835 ALKALI DR STE M	LEMOORE	KINGS	09/01/2002	
1215327804	LAKE COUNTY TRIBAL HEALTH CONSORTIUM INC	359 LAKEPORT BLVD	LAKEPORT	LAKE	04/23/2015	
1881697381	LAKE COUNTY TRIBAL HLTH	925 BEVINS COURT	LAKEPORT	LAKE	09/01/2002	
1770564049	LASSEN INDIAN HEALTH CTR	795 JOAQUIN ST	SUSANVILLE	LASSEN	09/01/2002	
1932329091	NORTH FORK INDIAN & COMM	32938 ROAD 222, STE 2	NORTH FORK	MADERA	09/01/2002	
1366519431	MACT HEALTH BOARD, INC MARIPOSA INDIAN HLTH CLN	5192 HOSPITAL ROAD	MARIPOSA	MARIPOSA	09/01/2002	
1003826009	CONSOLIDATED TRIBAL HEALTH PROJECT	6991 N. STATE STREET	REDWOOD VALLEY	MENDOCINO	09/01/2002	
1669532750	ROUND VALLEY INDIAN HLTH	CORNER HWY 162 AND BIGGAR LN	COVELO	MENDOCINO	09/01/2002	
1891762985	PIT RIVER HEALTH SVS	150 BIA ROUTE 76	ALTURAS	MODOC	09/01/2002	
1093931107	WARNER MOUNTAIN INDIAN HEALTH CLINIC	FT BIDWELL INDIAN RESERVATION	FORT BIDWELL	MODOC	03/03/2003	

‡ Address Change
‡‡Effective Date Change
*Alphabetical by County

NPI	LEGAL NAME	ADDRESS	CITY	COUNTY	EFFECTIVE DATE	DEACTIVATION DATE
1225331515	TOIYABE INDIAN HLTH PROJECT	73 CAMP ANTELOPE RD	COLEVILLE	MONO	09/08/2014	
1922138841	CHAPA-DE INDIAN HEALTH PROGRAM INC	1350 E. MAIN ST.	GRASS VALLEY	NEVADA	09/01/2002	
1114057163	CHAPA-DE INDIAN HEALTH PROGRAM	11670 ATWOOD ROAD	AUBURN	PLACER	09/01/2002	
1326031881	GREENVILLE RANCHERIA	410 MAIN STREET	GREENVILLE	PLUMAS	09/01/2002	
1619377942	DHEW IND HTLH SV HLTH SVS & MNTL HLTH ADM	9010 MAGNOLIA AVE	RIVERSIDE	RIVERSIDE	09/11/2014	
1639222144	RIVERSIDE-SAN BERNARDINO	39100 CONTRERAS RD STE F	ANZA	RIVERSIDE	02/01/2017	
1437202124	RIVERSIDE-SAN BERNARDINO	66735 MARTINEZ RD	THERMAL	RIVERSIDE	02/01/2017	
1639222144	RIVERSIDE-SAN BERNARDINO COUNTY INDIAN HEALTH INC	12784 PECHANGA RD	TEMECULA	RIVERSIDE	02/01/2017	
1639222144	RIVERSIDE-SAN BERNARDINO COUNTY INDIAN HEALTH INC	607 DONNA WAY	SAN JACINTO	RIVERSIDE	02/01/2017	
1437202124	RIVERSIDE-SAN BERNARDINO-COUNTY INDIAN HEALTH INC	11555 1/2 POTRERO	BANNING	RIVERSIDE	02/01/2017	
1174676670	RIVERSIDE-SAN BERNARDINO COUNTY INDIAN HEALTH INC	11980 MOUNT VERNON AVE	GRAND TERRACE	San Bernardino	02/01/2017	
1174676670	RIVERSIDE-SAN BERNARDINO COUNTY INDIAN HEALTH INC	170 YUCCA AVE	BARSTOW	San Bernardino	02/01/2017	

‡ Address Change
‡‡Effective Date Change
*Alphabetical by County

NPI	LEGAL NAME	ADDRESS	CITY	COUNTY	EFFECTIVE DATE	DEACTIVATION DATE
1346247947	SOUTHERN INDIAN HEALTH COUNCIL	4058 WILLOWS RD	ALPINE	SAN DIEGO	09/01/2002	
1922090885	SOUTHERN INDIAN HEALTH COUNCIL	36350 CHURCH RD	CAMPO	SAN DIEGO	09/01/2002	
1427197078	SYCUAN TRIBAL GOVERNMENT	5442 SYCAUN RD	EL CAJON	SAN DIEGO	06/24/2015	
1992779417	SANTA YNEZ TRIBAL HEALTH CLINIC	90 VIA JUANA RD	SANTA YNEZ	SANTA BARBARA	01/01/2014	
1891762985	PIT RIVER HEALTH SVS	36977 PARK AVENUE	BURNEY	SHASTA	09/01/2002	
1164807533	REDDING RANCHERIA	3184 CHURN CREEK	REDDING	SHASTA	07/30/2015	
1104859354	REDDING RANCHERIA HEALTH SERVICE	1441 LIBERTY ST	REDDING	SHASTA	09/01/2002	
1730279423	KARUK TRIBE	1519 SOUTH OREGON STREET	YREKA	SISKIYOU	09/01/2002	
1730279423	KARUK TRIBE	1515 S OREGON ST	YREKA	SISKIYOU	02/27/2017	
1952483406	KARUK TRIBE OF CALIF	64236 SECOND AVENUE	HAPPY CAMP	SISKIYOU	09/01/2002	
1306062419	QUARTZ VALLEY INDIAN RSV	9024 SNIKTAW ROAD	FORT JONES	SISKIYOU	02/11/2008	
1306062419	QUARTZ VALLEY INDIAN RSV	237 BUTTE STREET	FORT JONES	SISKIYOU	8/16/2016	

‡ Address Change
‡‡Effective Date Change
*Alphabetical by County

NPI	LEGAL NAME	ADDRESS	CITY	COUNTY	EFFECTIVE DATE	DEACTIVATION DATE
1306062419	QUARTZ VALLEY INDIAN RSV	220 COLLIER WAY	ETNA	SISKIYOU	8/16/2016	
1306062419	QUARTZ VALLEY INDIAN RSV	400 HOWELL AVE	ETNA	SISKIYOU	8/16/2016	
1306062419	QUARTZ VALLEY INDIAN RSV	11501 MATTHEWS ST	FORT JONES	SISKIYOU	3/21/2016	
1265457980	SONOMA CO INDIAN HEALTH PROJECT	144 STONY POINT ROAD	SANTA ROSA	SONOMA	09/01/2002	
1588826374	FEATHER RIVER TRIBAL HEALTH INC	555 W ONSTOTT RD	YUBA CITY	SUTTER	09/01/2002	
1164780573	GREENVILLE RANCHERIA	343 OAK STREET	RED BLUFF	TEHAMA	03/13/2013	
1568455053	GREENVILLE RANCHERIA TRIBAL HEALTH PROGRAM	1425 MONTGOMERY ROAD	RED BLUFF	TEHAMA	09/01/2002	
1588799449	NORTHERN VALLEY INDIAN HEALTH, INC	2500 NORTH MAIN ST	RED BLUFF	TEHAMA	11/04/2004	
1679988950	ROLLING HILLS CLINIC	2540 SISTER MAY COLUMBA DR	RED BLUFF	TEHAMA	03/18/2015	
1992012306	ROLLING HILLS CLINIC	740 SOLANO ST	CORNING	TEHAMA	03/18/2011	
1386164580	REDDING RANCHERIA‡‡	31660 HWY 3	WEAVERVILLE	TRINITY	8/15/2017	
1972586972	TULE RIVER INDIAN HEALTH	MOUNTAIN RD 137	PORTERVILLE	TULARE	09/01/2002	

‡ Address Change
‡‡Effective Date Change
*Alphabetical by County

NPI	LEGAL NAME	ADDRESS	CITY	COUNTY	EFFECTIVE DATE	DEACTIVATION DATE
1366519431	MACT HEALTH BOARD, INC	13975 MONO WAY STE G & I	SONORA	TUOLUMNE	09/01/2002	
1255595484	MATHIESEN MEMORIAL HEALTH CLINIC	18144 SECO ST	JAMESTOWN	TUOLUMNE	10/09/2008	
1124286885	TUOLUMNE ME-WUK INDIAN HEALTH	22044 CEDAR RD RD	SONORA	TUOLUMNE	08/19/2008	
1619952397	TUOLUMNE ME-WUK INDIAN HEALTH CENTER, INC	18800 CHERRY VALLEY BLVD.	TUOLUMNE	TUOLUMNE	12/21/2005	
1881960128	NORTHERN VALLEY INDIAN HEALTH, INC	175 WEST COURT STREET	WOODLAND	YOLO	07/02/2012	
1851678585	DHHS IHS PHOENIX AREA	12033 AGENCY RD	PARKER	OUT OF STATE AZ	02/26/2013	
1306897962	FORT MOJAVE INDIAN TRIBE	1607 PLANTATION RD	MOHAVE VALLEY	OUT OF STATE AZ	08/23/2010	
1396778379	WASHOE TRIBE OF NV & CA	1559 WATASHEAMU RD	GARDNERVILLE	OUT OF STATE NV	09/01/2002	
1750338646	YERINGTON PAIUTE TRIBAL COUNCIL	171 CAMPBELL LANE	YERINGTON	OUT OF STATE NV	10/29/2012	

‡ Address Change
‡‡Effective Date Change
*Alphabetical by County

American Indian Health Program Rates	**CY 2018 Rates**
Dual Rate (Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only)[1]	$287.72
Non-Dual Rate (Medi-Cal beneficiaries that do not have Medicare Coverage or has Medicare Part A only)	$427.00

[1] To illustrate using the amounts applicable in 2018: The "Outpatient Per Visit Rate (Excluding Medicare)" is $427.00. The 42 USC 1395w-4 Medicare PPS rate calculated using the Geographic Adjustment Factor (GAF) for Locality #75 (Rest of California) is equal to $174.10, which is the product of base PPS rate of $166.60 multiplied by the GAF of 1.045. The 80 percent multiplier reduces this PPS rate to $139.28 (the 20 percent reduction accounts for any coinsurance requirements that would be covered by Medi-Cal for dual eligible beneficiaries.). Thus the required payment is $287.72.

Back to Agenda

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: July 10, 2018

ALL PLAN LETTER 18-008 *(REVISED)*
SUPERSEDES All PLAN LETTER 15-019

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: CONTINUITY OF CARE FOR MEDI-CAL MEMBERS WHO TRANSITION INTO MEDI-CAL MANAGED CARE

PURPOSE:
The Department of Health Care Services (DHCS) is issuing this All Plan Letter (APL) to clarify continuity of care requirements for Medi-Cal members who transition into Medi-Cal managed care.[1] *This APL supersedes APL 15-019*.[2] *Revised text is found in italics.*

POLICY:
Medi-Cal members assigned a mandatory aid code and who are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal managed care health plan (MCP) have the right to request continuity of care in accordance with state law, and the MCP contract, with some exceptions. All MCP members with pre-existing provider relationships who make a continuity of care request to an MCP must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another MCP.

MCPs must provide continuity of care with an out-of-network provider when:

1. The MCP is able to determine that the member has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider).

    a. An existing relationship means the member has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment in the MCP for a non-emergency visit, unless otherwise specified in this APL.

[1] *Continuity of care provisions for dual-eligible members (members eligible for both Medi-Cal and Medicare) in the Cal MediConnect program can be found at the following link:* http://www.dhcs.ca.gov/formsandpubs/Pages/MgdCareDualsPlanLetters.aspx
[2] *APLs can be accessed at the following link:* http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

2. The provider is willing to accept the higher of the MCP's contract rates or Medi-Cal FFS rates.

3. The provider meets the MCP's applicable professional standards and has no disqualifying quality of care issues (for the purposes of this APL, a quality of care issue means *the* MCP can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other MCP members).

4. The provider is a California State Plan approved provider.

5. The provider supplies the MCP with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

MCPs are not required to provide continuity of care for services not covered by Medi-Cal. In addition, provider continuity of care protections do not extend to the *following:* durable medical equipment, transportation, other ancillary *service*, and carved-out service *providers*.

If a member changes MCPs, the 12-month continuity of care period may start over one time. If the member changes MCPs a second time (or more), the continuity of care period does not start over*;* the member does not have the right to a new 12 months of continuity of care. If the member returns to Medi-Cal FFS and later reenrolls in an MCP, the continuity of care period does not start over. If a member changes MCPs, this continuity of care policy does not extend to providers that the member accessed through their previous MCP.

MCP Processes

Members, their authorized representatives on file with Medi-Cal, or their provider, may make a direct request to an MCP for continuity of care. When this occurs, the MCP must begin to process the request within five working days following the receipt of the request. However, as noted below, the request must be completed in three calendar days if there is a risk of harm to the member. For the purposes of this APL, "risk of harm" is defined as an imminent and serious threat to the health of the member. The continuity of care process begins when the MCP starts the process to determine if the member has a pre-existing relationship with the provider.

MCPs must accept requests for continuity of care over the telephone, according to the requester's preference, and must not require the requester to complete and submit a paper or computer form if the requester prefers to make the request by telephone. To

complete a telephone request, the MCP may take any necessary information from the requester over the telephone.

MCPs must retroactively approve a continuity of care request and reimburse providers for services that were already provided if the request meets all continuity of care requirements described above and the services that are the subject of the request meet the following requirements:

- *Occurred after the member's enrollment into the MCP*
- *Have dates of service after December 29, 2014* [3]
- *Have dates of service that are within 30 calendar days of the first service for which the provider requests retroactive continuity of care reimbursement*

Retroactive continuity of care reimbursement requests must be submitted within 30 calendar days of the first service to which the request applies.

Validating Pre-existing Relationship
The MCP should determine if a relationship exists through use of data provided by DHCS to the MCP, such as Medi-Cal FFS utilization data. A member or his or her provider may also provide information to the MCP *that d*emonstrates a pre-existing relationship with *the* provider. A *member's self-attestation of* a pre-existing relationship *is not sufficient proof* (instead, actual documentation must be provided), unless the MCP makes this option available to *the member*.

Following identification of a pre-existing relationship, the MCP must determine if the provider is an in-network provider. If the provider is not an in-network provider, the MCP must contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a continuity of care relationship for the member.

Request Completion Timeline
Each continuity of care request must be completed within the following timelines:

- Thirty calendar days from the date the MCP received the request;
- Fifteen calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
- Three calendar days if there is risk of harm to the member.

[3] The first APL that addressed retroactive requests for continuity of care was APL 14-021, which was dated December 29, 2014.

A continuity of care request is considered completed when:

- The MCP notifies the member, in the manner outlined above, that the request has been approved;
- The MCP and the out-of-network Medi-Cal FFS provider are unable to agree to a rate;
- The MCP has documented quality of care issues with the Medi-Cal FFS provider;
- or
- The MCP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

Requirements after the Request Process is Completed

If *the* MCP and the out-of-network *Medi-Cal* FFS provider are unable to reach an agreement because they cannot agree to a rate, or the MCP has documented quality of care issues with the provider, the MCP will offer the member an in-network alternative. If the member does not make a choice, the member will be referred or assigned to an in-network provider. If the member disagrees with the result of the continuity of care process, the member maintains the right to *file a grievance*.

If a provider meets all of the necessary requirements, including *entering into a* letter of agreement or contract with the MCP, the MCP must allow the member to have access to that provider for the length of the continuity of care period unless the provider is only willing to work with the MCP for a shorter timeframe. In this case, the MCP must allow the member to have access to that provider for the shorter period of time.

At any time, members may change their provider to an in-network provider regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the MCP must work with the provider to establish a care plan for the member.

Upon approval of a continuity of care request, the MCP must notify the member of the following within seven calendar days:

- The request approval.
- The duration of the continuity of care arrangement.
- The process that will occur to transition the member's care at the end of the continuity of care period.
- The member's right to choose a different provider from the MCP's provider network.

Back to Agenda

The MCP must notify the member 30 calendar days before the end of the continuity of care period about the process that will occur to transition *the member's* care *to an in-network provider* at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

MCP Extended Continuity of Care Option
MCPs may choose to work with *a member's* out-of-network provider past the 12-month continuity of care period*; however, MCPs are* not required to do so to fulfill *the* obligations under this APL *or the MCP contract*.

Member and Provider Outreach and Education
MCPs must inform members of their continuity of care protections and must include information about these protections in member information packets and handbooks. This information must include how the member and provider initiate a continuity of care request with the MCP. The MCP must translate these documents into threshold languages and make them available in alternative formats, upon request. MCPs must provide training to call center and other staff who come into regular contact with members about continuity of care protections.

Provider Referral Outside of the MCP Network
An approved out-of-network provider must work with the MCP and its contracted network and must not refer the member to another out-of-network provider without authorization from the MCP. In such cases, the MCP will make the referral, if medically necessary, if the MCP does not have an appropriate provider within its network.

NON-SPECIALTY MENTAL HEALTH SERVICES – CONTINUITY OF CARE FOR APPROVED PROVIDER TYPES:

MCPs are required to cover outpatient mental health services, as outlined in APL 17-018, for members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health condition, as defined by the current Diagnostic and Statistical Manual.[4] County Mental Health Plans (MHPs) are required to provide specialty mental health services (SMHS) for members who meet the medical necessity criteria for SMHS. DHCS recognizes that the medical necessity criteria for impairment and intervention for SMHS differ between children and adults. Under the Early and Periodic Screening, Diagnostic, and Treatment benefit, the impairment component of the SMHS medical necessity criteria for members under 21 years of age

[4] *APL 17-018, "Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services," can be accessed at the following link: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx*

is less stringent than it is for adults. Therefore, children with a lower level of impairment may meet medical necessity criteria for SMHS.[5]

MCPs must provide continuity of care with an out-of-network SMHS provider in instances where a member's mental health condition has stabilized such that the member no longer qualifies to receive SMHS from the MHP and instead becomes eligible to receive non-specialty mental health services from the MCP. In this situation, the continuity of care requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medicaid State Plan, to provide outpatient, non-specialty mental health services (referred to in the State Plan as "Psychology").[6]

The MCP must allow, at the request of the member, the provider, or the member's authorized representative, up to 12 months continuity of care with the out-of-network MHP provider in accordance with the requirements in this APL. After the continuity of care period ends, the member must choose a mental health provider in the MCP's network for non-specialty mental health services. If the member later requires additional SMHS from the MHP to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to the MCP for non-specialty mental health services, the 12-month continuity of care period may start over one time. If the member requires SMHS from the MHP subsequent to the continuity of care period, the continuity of care period does not start over when the member returns to the MCP or changes MCPs (i.e., the member does not have the right to a new 12 months of continuity of care).

COVERED CALIFORNIA TO MEDI-CAL TRANSITION:
This section specifies requirements for populations that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage due to the Covered California yearly coverage renewal determination or changes in a member's eligibility circumstances that may occur at any time throughout the year. These requirements are limited to these transitioning members.

To ensure that continuity of care and coordination of care requirements are met, the MCP must ask these members if there are upcoming health care appointments or treatments scheduled and assist them, if they choose to do so, in initiating the continuity of care process at that time according to the provider and service continuity rights described below or other applicable continuity of care rights. When a new member

[5] *SMHS medical necessity criteria are outlined in Title 9 of the California Code of Regulations (CCR), Sections 1830.205 and 1830.210. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index*
[6] *State Plan Amendment (SPA) 14-012, Attachment 3.1-A is available at: http://www.dhcs.ca.gov/formsandpubs/laws/Documents/CASPA14-012ApprovedPackageOriginalADA.pdf*

enrolls in Medi-Cal, the MCP must contact the member by telephone, letter, or other resources no later than 15 days after enrollment. The requirements noted above in this paragraph must be included in this initial member contact process. The MCP must make a good faith effort to learn from and obtain information from the member so that it is able to honor active prior treatment authorizations and/or establish out-of-network provider continuity of care as described below.

The MCP must honor any active prior treatment authorizations for up to 60 days or until a new assessment is completed by the MCP. A new assessment is considered completed by the MCP if the member has been seen by an MCP-contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The prior treatment authorizations must be honored without a request by the member or the provider.

The MCP must, at the member's or provider's request, offer up to 12 months of continuity of care with out-of-network providers, in accordance with *the requirements in this APL.*

HEALTH HOMES PROGRAM – MEDI-CAL FFS TO MANAGED CARE TRANSITION:
MCPs must provide continuity of care with an out-of-network provider, in accordance with the requirements of this APL, for Medi-Cal FFS beneficiaries who voluntarily transition to an MCP to enroll in the Health Homes Program (HHP).[7] *Because HHP services are provided only through the managed care delivery system, continuity of care with out-of-network-providers is not available for HHP services.*

SENIORS AND PERSONS WITH DISABILITIES FFS TREATMENT AUTHORIZATION REQUEST CONTINUITY UPON MCP ENROLLMENT:
For a newly enrolled Seniors and Persons with Disabilities (SPDs), the MCP must honor any active FFS Treatment Authorization Requests (TARs) for up to 60 days or until a new assessment is completed by the MCP. A new assessment is considered completed by the MCP if the member has been seen by an MCP-contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The FFS TAR must be honored as outlined above without a request by the member or the provider.

[7] *More information on the Health Home Program services can be found here:* http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx.

Back to Agenda

BEHAVIORAL HEALTH TREATMENT FOR MEMBERS UNDER THE AGE OF 21 UPON MCP TRANSITION:

MCPs are responsible for providing Early and Periodic Screening, Diagnostic, and Treatment services for members under the age of 21. Services include medically necessary Behavioral Health Treatment (BHT) services that are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. In accordance with existing contract requirements and the requirements listed in this APL and APL 18-006, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21, MCPs must offer members continued access to out-of-network BHT providers (continuity of care) for up to 12 months if all requirements in this APL are met. For BHT, an existing relationship means a member has seen the out-of-network BHT provider at least one time during the six months prior to either the transition of services from a Regional Center (RC) to the MCP or the date of the member's initial enrollment in the MCP if enrollment occurred on or after July 1, 2018. Further, if the member has an existing relationship, as defined above, with an in-network provider, the MCP must assign the member to that provider to continue BHT services.

Retroactive requests for BHT service continuity of care reimbursement are limited to services that were provided after a member's transition date into an MCP, or the date of the member's enrollment into the MCP, if the enrollment date occurred after the transition.

MCPs must continue ongoing BHT services until they have conducted an assessment and established a behavioral treatment plan.

<u>Transition of BHT Services from RCs to MCPs</u>

At least 45 days prior to the transition date, DHCS will provide MCPs with a list of members for whom the responsibility for BHT services will transition from RCs to MCPs, as well as member-specific utilization data. MCPs must consider every member transitioning from an RC as an automatic continuity of care request. DHCS will also provide MCPs with member utilization and assessment data from the RC prior to the service transition date. MCPs are required to use DHCS-supplied utilization data to identify each member's BHT provider(s) and proactively contact the provider(s) to begin the continuity of care process, regardless of whether a member's parent or guardian files a request for continuity of care. If the data file indicates that multiple providers of the same type meet the criteria for continuity of care, the MCP should attempt to contact the member's parent or guardian to determine *their* preference. If the MCP does not have access to member data that identifies an existing BHT provider, the MCP must contact the member's parent or guardian by telephone, letter, or other resources, and make a good faith effort to obtain information that will assist the MCP in offering

Back to Agenda

continuity of care. If the RC is unwilling to release specific provider rate information to the MCP, then the MCP may negotiate rates with the continuity of care provider without being bound by the usual requirement that the MCP offer at least a minimum FFS-equivalent rate. If the MCP is unable to complete a continuity of care agreement, the MCP must ensure that all ongoing services continue at the same level with an MCP in-network provider until the MCP has conducted an evaluation and/or assessment, as appropriate, and established a treatment plan.

MCPs may refer to the Continuity of Care section of APL 18-006 for additional requirements and information regarding continuity of care for transitioning members receiving BHT.

EXISTING CONTINUITY OF CARE PROVISIONS UNDER CALIFORNIA STATE LAW:

In addition to the protections set forth above, MCP members also have rights to protections set forth in current state law pertaining to continuity of care. In accordance with Welfare and Institutions Code Section (§) 14185(b), MCPs must allow members to continue use of any (single-source) drugs that are part of a prescribed therapy (by a contracting or non-contracting provider) in effect for the member immediately prior to the date of enrollment, whether or not the drug is covered by the MCP, until the prescribed therapy is no longer prescribed by the MCP-contracting provider.

Additional requirements pertaining to continuity of care are set forth in Health and Safety Code *(HSC)* §1373.96 and require health plans in California to, at the request of a member, provide for the completion of covered services by a terminated or nonparticipating health plan provider. Under *HSC* §1373.96, health plans are required to complete services for the following conditions: acute, serious chronic, pregnancy, terminal illness, the care of a newborn child between birth and age 36 months, and performance of a surgery or other procedure that is authorized by the MCP as a part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered member. This APL does not alter *the* MCP's obligation to fully comply with the requirements of *HSC* §1373.96. In addition to the requirements set forth in this APL, each MCP must allow for completion of covered services as required by *HSC* §1373.96, to the extent that doing so would allow a member a longer period of treatment by an out-of-network provider than would otherwise be required under the terms of this this APL. MCPs must allow for the completion of these services for certain timeframes which are specific to each condition and defined under *HSC* §1373.96.

Back to Agenda

PREGNANT AND POST-PARTUM BENEFICIARIES:
As noted above, *HSC* §1373.96 requires health plans in California to, at the request of a member, provide for the completion of covered services relating to pregnancy, during pregnancy and immediately after the delivery (the post-partum period), and care of a newborn child between birth and age 36 months, by a terminated or nonparticipating health plan provider. These requirements will apply for pregnant and post-partum members and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements. Please refer to *HSC* §1373.96 for additional information about applicable circumstances and requirements.

Pregnant and post-partum Medi-Cal members who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into an MCP have the right to request out-of-network provider continuity of care for up to 12 months in accordance with *the* MCP contract and the general requirements listed in this APL. This requirement is applicable to any existing Medi-Cal FFS provider relationship that is allowed under the general requirements of this APL (continuity of care for members transitioning from FFS to managed care).

MEDICAL EXEMPTION REQUESTS:
A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into an MCP only until the member's medical condition has stabilized to a level that would enable the member to transfer to an MCP provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from MCP enrollment that only applies to members transitioning from Medi-Cal FFS to an MCP. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above in this paragraph. MCPs are required to consider MERs that have been denied as automatic continuity of care requests to allow members to complete courses of treatment with Medi-Cal FFS providers in accordance with *APL 17-007.*[8]

REPORTING:
MCPs may be required to report on metrics related to any continuity of care provisions outlined in this APL, state law and regulations, or other state guidance documents at any time and in a manner determined by DHCS.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, *and Policy Letters*. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

[8] *APLs can be accessed at the following link:* http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

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

Back to Agenda

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 7, 2018

ALL PLAN LETTER 18-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE WHOLE CHILD MODEL PROGRAM

SUBJECT: CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL PROGRAM

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide direction to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 04-0618,[1] which provides direction and guidance to county CCS programs on requirements pertaining to the implementation of the WCM program.

BACKGROUND:
Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties.[2] The purpose of the WCM program is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. MCPs operating in WCM counties will integrate Medi-Cal managed care and county CCS Program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.[3, 4]

MCPs will authorize care that is consistent with CCS Program standards and provided by CCS-paneled providers, approved special care centers, and approved pediatric acute care hospitals. The WCM program will support active participation by parents and families of CCS-eligible members and ensure that members receive protections such as

[1] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[2] SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
[3] See Health and Safety Code (HSC) Section 123850(b)(1), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=123850.
[4] See Welfare and Institutions Code (WIC) Section 14094.11, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

continuity of care (COC), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning no sooner than July 1, 2018. Upon determination by DHCS of the MCPs' readiness to address the needs of the CCS-eligible members, MCPs must transition CCS-eligible members into their MCP network of providers by their scheduled implementation date as follows:

MCP	COHS Counties
Phase 1 – No sooner than July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
Phase 2 – No sooner than January 1, 2019	
CalOptima	Orange
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo

POLICY:
Starting no sooner than July 1, 2018, MCPs in designated counties shall assume full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services, including service authorization activities, claims processing and payment, case management, and quality oversight.

Under the WCM, the MCP, county CCS program, and DHCS will each bear responsibility for various administrative functions to support the CCS Program. Responsibilities for the CCS Program's eligibility functions under the WCM are determined by whether the county CCS program operates as an independent or dependent county.[5] Independent CCS counties will maintain responsibility for CCS Program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS Program medical eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS will continue to maintain responsibility for CCS Program medical eligibility determinations and redeterminations, while the county CCS programs will maintain responsibility for financial and residential eligibility determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical

[5] A link to the Division of Responsibility chart can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

Back to Agenda

redetermination and other medical determinations, as needed, for the CCS-eligible member.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS Program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage (OHC), with full scope Medi-Cal as payor of last resort.

The implementation of WCM does not impact the activities and functions of the Medical Therapy Program (MTP) and Pediatric Palliative Care Waiver (PPCW). WCM counties participating with the MTP and PPCW will continue to receive a separate allocation for these programs. The MCP is responsible for care coordination of services that remain carved-out of the MCP's contractual responsibilities.

MCPs are required to use all current and applicable CCS Program guidelines, including CCS Program regulations, additional forthcoming regulations related to the WCM program, CCS Numbered Letters (N.L.s),[6] and county CCS program information notices, in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations and contractual requirements.

I. MCP AND COUNTY COORDINATION

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members. A quarterly meeting between the MCP and the county CCS program must be established to assist with overall coordination by updating policies, procedures, and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding (MOU) and other WCM related matters.

A. Memorandum of Understanding

MCPs and county CCS programs must execute a MOU outlining their respective responsibilities and obligations under the WCM using the MOU template posted on the CCS WCM page of the DHCS website.[7] The purpose of the MOU is to explain how the MCPs and county CCS programs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP will serve as the primary vehicle for ensuring

[6] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[7] A link to the MOU template can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

collaboration between the MCP and county CCS program. The MOU can be customized based on the needs of the individual county CCS program and the MCP, consistent with the requirements of SB 586 and dependent upon DHCS approval. The MOU must include, at a minimum, all of the provisions specified in the MOU template. Phase 1 MCPs must have submitted an executed MOU, or proved intent and/or progress made towards an executed MOU, by March 31, 2018. Phase 2 MCPs must submit an executed MOU, or prove intent and/or progress made toward an executed MOU, by September 28, 2018. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS beneficiaries into managed care for treatment of their CCS-eligible conditions. The transition plan must describe collaboration between the MCP and the county CCS program on the transfer of case management, care coordination, provider referrals, and service authorization administrative functions from the county CCS program to the MCPs.[8] The transition plan must also include communication with beneficiaries regarding, but not limited to, authorizations, provider network, case management, and ensuring continuity of care and services for beneficiaries in the process of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

C. Inter-County Transfer

County CCS programs use CMSNet to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. Through their respective MOUs, the MCPs and county CCS programs will develop protocols for the exchange of ICT data, as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of the CCS member and allow for COC of already approved service authorization requests, as required by this APL and applicable state and federal laws.

When a CCS-eligible member moves from a WCM county to a non-WCM county, the county CCS program and MCP, through their respective MOUs, will exchange ICT data. County CCS programs will continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS eligible member moves out of a WCM county, the county CCS program will notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data

[8] See WIC Section 14094.7(d)(4)(C), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.7.

for members to the county CCS program office. The county CCS program will then coordinate the sharing of CCS-eligible member data to the new county of residence. Similarly, when a member moves into a WCM county, the county CCS program will provide transfer data to the MCP as applicable.

D. Dispute Resolution and Provider Grievances

Disagreements between the MCP and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS.[9] The county CCS program shall communicate all resolved disputes in writing to the MCP within a timely manner. Disputes between the MCP and the county CCS program that are unable to be resolved will be referred by either entity to DHCS, via email to CCSWCM@dhcs.ca.gov, for review and final determination.[10]

MCPs must have a formal process to accept, acknowledge, and resolve provider disputes and grievances.[11] A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the MCP directly to the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

II. MCP RESPONSIBILITIES TO CCS-ELIGIBLE MEMBERS

A. Risk Level and Needs Assessment Process

The MCP will assess each CCS child's or youth's risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data, or by other means. MCPs are required to develop and complete the risk assessment process for WCM transition members, newly CCS-eligible members, or new CCS members enrolling in the MCP. The risk assessment process must include the development of a pediatric risk stratification process (PRSP) and an Individual Care Plan (ICP) for high risk members. All requirements are dependent on the member's risk level that is determined through the PRSP. Furthermore, nothing in this APL shall remove or limit existing survey or assessment requirements that the MCPs are responsible for outside WCM.

---

[9] See WIC Section 14093.06(b), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14093.06.
[10] Unresolved disputes must be referred to: CCSWCM@dhcs.ca.gov
[11] See WIC Section 14094.15(d), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.15.

1. **Pediatric Risk Stratification Process**
   MCPs must develop a pediatric risk stratification mechanism, or algorithm, to assess the CCS-eligible member's risk level that will be used to classify members into high and low risk categories, allowing the MCP to identify members who have more complex health care needs.

   MCPs are required to complete a risk stratification within 45 days of enrollment for all members including new members, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level by:

   - Review of medical utilization and claims processing data, including data received from the county and DHCS;
   - Utilization of existing member assessment or survey data; and
   - Telephonic or in-person communications, if available at time of PRSP.

   Members that do not have any medical utilization data, claims processing data history, or other assessments and/or survey information available will automatically be categorized as high risk until further assessment data is gathered to make an additional risk determination. The PRSP must be submitted to DHCS for review and approval.

2. **Risk Assessment and Individual Care Plan Process**
   MCPs must develop a process to assess a member's current health, including the CCS condition, to ensure that each CCS-eligible member receives case management, care coordination, provider referral, and/or service authorization from a CCS paneled provider; this will be dependent upon the member's designation as high or low risk.

   New Members and Newly CCS-eligible Members Determined High Risk
   Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of the member's ICP. Any risk assessment survey created by the MCP for the purposes of WCM is subject to review and approval by DHCS.

   Risk Assessment
   The risk assessment process must address:

   a) General Health Status and Recent Health Care Utilization. This may include, but is not limited to, caretaker self-report of child's health;

outpatient, emergency room, or inpatient visits; and school days missed due to illness, over a specified duration of time.

b) Health History. This includes both CCS and non-CCS diagnoses and past surgeries.

c) Specialty Provider Referral Needs.

d) Prescription Medication Utilization.

e) Specialized or Customized Durable Medical Equipment (DME) Needs (if applicable).

f) Need for Specialized Therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies (PT/OT /ST), mental or behavioral health services, and educational or developmental services.

g) Limitations of Activities of Daily Living or Daily Functioning (if applicable).

h) Demographics and Social History. This may include, but is not limited to, member demographics, assessment of home and school environments, and cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to assess the need for or impact of future health care services. These may include, but are not limited to, questions related to childhood developmental milestones; pediatric depression, anxiety or attention deficit screening; adolescent substance use; or adolescent sexual behaviors.

Individual Care Plan
MCPs are required to establish an ICP for all members determined high risk based on the results of the risk assessment process, with particular focus on specialty care, within 90 days of a completed risk assessment survey or other assessment by telephonic and/or in-person communication.[12] The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);
- County substance use disorder (SUD) or Drug Medi-Cal services;

[12] See WIC Section 14094.11(b)(4), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

The ICP will be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or their designated caregiver. The ICP should indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP should also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

a) Access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an interdisciplinary team is, and what the community resources are.

b) A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions.

c) Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams.

d) Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

Further, the MCP must reassess the member's risk level and needs annually at their CCS eligibility redetermination or upon significant change to the member's condition.

[13] See WIC Section 14094.11(c), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

New Members and Newly CCS-eligible Members Determined Low Risk
For new members and newly CCS-eligible members identified as lower risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of their enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

The MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination or upon significant change to the member's condition.

WCM Transitioning Members
For WCM transition members, the MCP must complete the PRSP within 45 days of transition, to determine each member's risk level, and complete all required telephonic and/or in-person communication and ICPs for high risk members and all required telephonic and/or in-person communication for low risk members within one year. Additionally, the MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination, or upon significant change to the member's condition.

MCPs must submit to DHCS for review and approval a phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year for WCM transition members.

Regardless of the risk level of a member, all communications, whether by phone or mail, must inform the member and/or his or her designated caregiver that the assessment will be provided in a linguistically and culturally appropriate manner and identify the method by which the provider will arrange for an in-person assessment.[14]

MCPs must refer all members, including new members, newly CCS-eligible members and WCM transition members who may have developed a new CCS-eligible condition, immediately to the county for CCS eligibility determination and not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination
MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs must ensure that information, education and support is continuously provided to the CCS-eligible member and their family to

[14] See APL 99-005, which is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL1999/MMCDAPL99005.pdf

assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:[15]

- Primary and preventive care services with specialty care services
- Medical therapy units (MTU)
- EPSDT[16]
- Regional center services
- Home and community-based services

1. **High Risk Infant Follow-Up Program**
   High Risk Infant Follow-Up (HRIF) is a program that helps identify infants who might develop CCS-eligible conditions after they are discharged from a Neonatal Intensive Care Unit (NICU). The MCP is responsible for coordinating and authorizing HRIF services for members and ensuring HRIF case management services. MCPs must notify the counties in writing, within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide COC information to the members.

2. **Age-Out Planning Responsibility**
   MCPs must establish and maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the members' CCS qualifying condition(s).

   MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[17]

3. **Pediatric Provider Phase-Out Plan**
   A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment to the child or youth. The MCPs must provide care coordination to

[15] See WIC Section14094.11(b)(1)-(6), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.11.
[16] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See APL 18-007, which is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-007.pdf
[17] See WIC Section 14094.12(j), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.12.

CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the service of a pediatric provider. The timing of the transition should be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

C. Continuity of Care

MCPs must establish and maintain a process to allow for members to receive COC with existing CCS provider(s) for up to 12 months, in accordance with WIC Section 14094.13.[18] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all other applicable APLs regarding COC. The sections below include additional COC requirements that only pertain to the WCM program.

1. Specialized or Customized Durable Medical Equipment

If the MCP member has an established relationship with a specialized or customized durable medical equipment (DME) provider, MCPs must provide access to that provider for up to 12 months.[19] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service rates, unless the DME provider and the MCP enter into an agreement on an alternative payment methodology that is mutually agreed upon. The MCP may extend the COC period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[20]

Specialized or Customized DME must meet all of the following criteria:

- Is uniquely constructed or substantially modified solely for the use of the member.
- Is made to order or adapted to meet the specific needs of the member.
- Is uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

2. COC Case Management[21]

MCPs must ensure CCS-eligible members receive expert case management,

[18] See WIC Section 14094.13, which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.13.
[19] See WIC Section 14094.12(f), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.12.&lawCode=WIC
[20] See WIC Section 14094.13(b)(3) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[21] See WIC Section 14094.13(e), (f) and (g), which are available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing the CCS-eligible member, member's family, or designated caregiver to request COC case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with a MCP case manager who has received adequate training on the county CCS Program and who has clinical experience with the CCS population or pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services The MCP must send a follow-up notice 30 days prior to the start of the transition.

3. **Authorized Prescription Drugs**
   CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed prescription drug that is part of their prescribed therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.[22]

4. **Appealing COC Limitations**
   MCPs must provide CCS-eligible members with information regarding the WCM appeal process for COC limitations, in writing, 60 days prior to the end of their authorized COC period. The notice must explain the member's right to petition the MCP for an extension of the COC period, the criteria used to evaluate the petition, and the appeals process if the MCP denies the petition.[23] The appeals process notice must include the following information:

   - The CCS-eligible member must first appeal a COC decision with the MCP.
   - A CCS-eligible member, member's family or designated caregiver of the CCS-eligible member may appeal the COC limitation to the DHCS director or his or her designee after exhausting the MCP's appeal process.

[22] See WIC Section 14094.13(d)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[23] See WIC Section 14094.13(k), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

- The DHCS director or designee will have five (5) days from the date of appeal to inform the family or caregiver of receipt of the request and must provide a decision on the appeal within 30 calendar days from the date of the request. If the member's health is at risk, the DHCS director or designee will inform the member of the decision within 72 hours.[24]

In addition to the protections set forth above, MCP members also have COC rights under current state law.

D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals and state fair hearing processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal and state fair hearing rights as provided under state and federal law.[25] MCPs must provide timely processes for accepting and acting upon member complaints and grievances. Members appealing a CCS eligibility determination must appeal to the county CCS program.

E. Transportation

MCPs must provide the CCS Maintenance and Transportation (M&T) benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary costs (i.e. parking, tolls, etc.), in addition to transportation expenses, and must comply with all requirements listed in N.L. 03-0810.[26] These services include, but are not limited to, M&T for out of county and out of state services.

MCPs must also comply with all requirements listed in APL 17-010[27] for CCS-eligible members to obtain non-emergency medical transportation (NEMT) and non-medical transportation (NMT) for all other services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.

[24] See APL 17-006, which is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf
[25] See APL 17-006
[26] See CCS N.L. 03-0810, which is available at: http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl030810.pdf
[27] APL 17-010 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-010.pdf

F. Out-of-Network Access

MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the MCP's provider network or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services.

G. Advisory Committees

MCPs must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers.[28] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[29] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also establish a quarterly Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.[30]

III. WCM Payment Structure

A. Payment and Fee Rate

MCPs are required to pay providers at rates that are at least equal to the applicable CCS fee-for-service rates, unless the provider and the MCP enter into

[28] See WIC Section 14094.7(d)(3), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.7.&lawCode=WIC
[29] See WIC Section 14094.17(b)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC
[30] See WIC Section 14094.17(a), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC

an agreement on an alternative payment methodology that is mutually agreed upon.[31]

The payor for NICU services is as follows: an MCP shall pay for NICU services in counties where NICU is carved into the MCP's rate, and DHCS shall pay in counties where NICU is carved out of the MCP's rate.[32]

For WCM counties, all NICU authorizations will be sent to the MCP in which the child is enrolled. The MCP will review authorizations and determine whether or not the services meet CCS NICU requirements. However, claims may be processed and paid by either DHCS or the MCP.

In counties where CCS NICU is carved into the MCP's rate, the MCP will pay all NICU and CCS NICU claims. For counties where CCS is currently carved-out, the MCP will process and pay non-CCS NICU claims, and the State's Fiscal Intermediary will pay CCS NICU claims. Payments made by State's Fiscal Intermediary will be based on the MCP's approval of meeting CCS NICU requirements.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities for WCM:

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-In Counties: Marin, Merced, Monterey, Napa, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, and Yolo	MCP	MCP	MCP

[31] See WIC Section 14094.16(b), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.16.
[32] See the Division of Responsibility chart

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-Out: Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Orange, Shasta, Siskiyou, Sonoma, and Trinity	MCP	MCP	DHCS

IV. MCP Responsibilities to DHCS

A. Network Certification

MCPs are required to have an adequate network of providers to serve the CCS-eligible population including physicians, specialists, allied professionals, Special Care Centers, hospitals, home health agencies, and specialized and customizable DME providers. Each network of providers will be reviewed by DHCS and certified annually.

The certification requires the MCP and their delegated entities to submit updated policies and procedures and an updated provider network template to ensure the MCP's network of providers meets network adequacy requirements as described in the Network Certification APL Attachments.[33]

MCPs must demonstrate that the provider network contains an adequate provider overlap with CCS-paneled providers. MCPs must submit provider network documentation to DHCS, as described in APL 18-005. Members cannot be limited to a single delegated entity's provider network. The MCP must ensure members have access to all medically necessary CCS-paneled providers within the MCP's entire provider network. MCPs must submit policies and procedures to DHCS no later than 105 days before the start of the contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional

[33] APL 18-005 and its attachments are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

approval status.[34] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[35] The MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[36]

MCPs are required to verify the credentials of all contracted CCS-paneled providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. The MCP's written policies and procedures must follow the credentialing and recredentialing guidelines of APL 17-019.[37] MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[38]

- Procedures for pre-authorization, concurrent review, and retrospective review.
- A list of services requiring prior authorization and the utilization review criteria.
- Procedures for the utilization review appeals process for providers and members.
- Procedures that specify timeframes for medical authorization.
- Procedures to detect both under- and over-utilization of health care services.

In addition to the UM processes above, MCPs are responsible for conducting NICU acuity assessments and authorizations in all WCM counties.[39]

---

[34] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[35] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[36] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf
[37] APL 17-019 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-019.pdf
[38] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[39] See WIC 14094.65, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.65.&lawCode=WIC

D. MCP Reporting Requirements

1. Quality Performance Measures

DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a form and manner specified by DHCS.

2. Reporting and Monitoring

DHCS will develop specific monitoring and oversight standards for MCPs. MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companions guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required data in a form and manner specified by DHCS and must comply with all contractual requirements.

E. Delegation of Authority

In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in APL 17-004.[40] If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[40] APL 17-004 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-004.pdf

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

9. Consider Authorizing Issuance of a Request for Proposal for Consulting Services to Assist in Analyzing the CalOptima Provider Network Strategy, Approving Related Scope of Work, and Expansion of Existing Engagement with Milliman, Inc. for Actuarial Services

Contact

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

Recommended Actions

1. ~~Authorize the Chief Executive Officer (CEO) to issue a Request for Proposal (RFP) for consulting services to provide data analysis and to perform a market survey related to the CalOptima provider network delivery system;~~
2. ~~Approve the related attached Scope of Work (SOW); and~~

Continued to 11/1/2018 meeting

3. Authorize the expansion of existing actuarial service engagement with Milliman, Inc. to include the exploration of risk adjustment methodologies that will allow for appropriate comparisons of financial and utilization metrics across different health network types and authorize expenditure of unbudgeted funds in an amount not to exceed $35,000 from reserves for this purpose.

Background

At the September 6, 2018 Board meeting, Management presented an Information Item on the CalOptima delivery system. As a follow up to that presentation, the Board directed Management to place an action item on the agenda for the October meeting to consider issuing an RFP to conduct a market study to analyze CalOptima's provider network strategy. Staff was also directed to seek input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the provider network delivery system.

Discussion

In response to the Board's directive, Staff considered the information that would be most helpful to the Board in evaluating the current delivery system and making recommendations on further refinements going forward. Staff has prepared the attached document delineating the proposed research information categories. The document also makes recommendations on whether information in each particular category would be gathered and presented by Staff, by expanding the scope of current consulting services being performed by Milliman, Inc., CalOptima's currently contracted actuarial consultants, or by engaging other outside consultant(s).

Milliman, Inc. currently provides CalOptima with actuarial services related to the Medicare bid development, capitation rebasing, and Chronic Illness and Disability Payment System (CDPS) risk scoring used to adjust health network capitation. These services are highly complex and require significant experience with CalOptima's data and business practices. Additional actuarial services as identified as the responsibilities of the "Existing Consultant" in the attachment are similar to services currently being performed and would be expedited by using Milliman, Inc.

Consistent with the Board's direction, Staff presented the same delivery system Information Items the Board received at its September 6th meeting to the MAC and PAC at their September 13, 2018,

Back to Agenda

meetings. MAC and PAC members have scheduled a special joint meeting on October 11, 2018, for further discussion on these topics.

Pursuant to CalOptima Policy GA.5002: Purchasing, Staff plans to generate an RFP for consulting services to complete data analysis and perform a market survey. Upon completion of the contracted work, the findings will provide additional information to assist the Board in evaluating the current state of CalOptima's healthcare delivery system and setting future direction.

As proposed, an evaluation team consisting of CalOptima's Executive Director of Network Operations, CEO, Chief Operating Officer, Chief Financial Officer, and Procurement Manager, will evaluate each of the proposals received. Management anticipates returning to the Board to request authority to contract with the recommended consulting services vendor as soon as the Board's December 6, 2018, meeting. Assuming the Board is in agreement with the categories and breakdown of Staff/consultant responsibilities as summarized in Attachment 1, the SOW for the RFP for consulting services would be limited to those items designated as the responsibilities of the "New Consultant" in the attachment.

Fiscal Impact

In the event the Board adopts the recommended actions authorizing the CEO to issue an RFP for consulting services to provide data analysis and perform a market survey and to approve the related SOW, the fiscal impact is unknown at this time. Upon completion of the RFP, Staff will return to the Board to request appropriate funding for the cost of the consulting services.

Should the Board adopt the recommended action to expand CalOptima's existing actuarial service engagement with Milliman, Inc. to include additional risk adjustment activities, it is an unbudgeted item. Management requests an amount not to exceed $35,000 from reserves to fund the recommended action.

Rationale for Recommendation

In response to the Board directive, Staff recommends the proposed steps, including conducting an RFP for consulting services and expanding the scope of the existing contract with Milliman, Inc. to obtain information to assist the Board in evaluating the current delivery system and setting direction going forward. Following completion of the RFP process, Staff will return to the Board with further recommendations.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities
2. Contracted Entity Covered by this Recommended Board Action

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

Back to Agenda

Attachment 1: Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

Requirement	Responsible Party			Additional Information
	CalOptima	Existing Consultant	New Consultant	
1. Explore various actuarial methodologies to risk adjust revenues and medical expenses across health network types to account for differences in population acuity and expenses.		√		This will allow for a more complete comparison of various utilization metrics and Medical Loss Ratio (MLR) calculations for Medi-Cal; without risk adjusted revenues and expenses, various comparisons are not appropriate.
2. Perform network MLR comparative analysis	√			CalOptima has data providing expense side of the calculation; need Req. 1 to risk adjust the revenue. Without risk adjusted revenue, the comparison is not appropriate.
3. Establish pre-contracting criteria for additional new health networks			√	CalOptima has pre-contracting criteria in place (from last RFP). A Consultant can be engaged to develop and propose minimum requirements that must be met prior to actual contracting.
4. Develop rationale and support for minimum/maximum membership limitation			√	Related to Req. 3, a Consultant can be engaged to provide an independent analysis and supporting rationale for minimum/maximum membership requirements.
5. Review current auto assignment criteria and model, including survey of other Southern California health plans criteria/model			√	CalOptima has methodology in place. A Consultant would be engaged to survey other plans and provide independent support for an auto assignment model and process.
6. Survey and verify payment methodologies used by health networks			√	A Consultant would be engaged to survey payment methodologies used to pay downstream providers, including primary care providers, specialists and hospitals.
7. Develop network performance evaluation tool/report card			√	CalOptima has surveyed several other Southern California health plans, and has most all of the various benchmarks, scorecards and performance criteria that can be used to develop a network performance evaluation tool/report card
8. Perform survey of other Southern California health plans to include Delegated – Direct model mix, payment models (i.e., capitation, FFS,			√	CalOptima has informally surveyed several other Southern California health plans and has a good understanding of the various network models and different

Back to Agenda

Attachment 1: Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

Requirement	Responsible Party			Additional Information
	CalOptima	Existing Consultant	New Consultant	
other) and other obtainable comparative metrics				payment methodologies currently in place. Additional work can be performed to provide a more complete understanding.
9. Review Member Satisfaction Survey – Provide analysis and key recommended actions that may impact the network delivery system	√		√	CalOptima can provide the analysis and recommended actions.
10. Review Provider Satisfaction Survey – Provide analysis and key recommended actions that may impact the network delivery system	√		√	CalOptima can provide the analysis and recommended actions.
11. Develop an administrative cost allocation model to allocate costs to the networks that is based on appropriate methodologies	√		√	CalOptima has an administrative cost allocation methodology in place. It is in the process of being reviewed and modified.

Back to Agenda

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Milliman	1301 Fifth Avenue, Suite 3800	Seattle	WA	98101-2646

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

Contact
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Action
Adopt Resolution approving updates to Human Resources Policies: GA.8032 Employee Dress Code; GA.8050 Confidentiality; and GA.8058 Salary Schedule.

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

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

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

	Policy No./Name	Summary of Changes	Reason for Change
1.	GA.8032 Employee Dress Code	• Clarify definitions of business casual and casual attire and provide specific detail of a professional dress code • Attachment has been revised to include only the employee acknowledgement	• To clarify dress code guidelines for a professional environment • To remove redundancy of policy
2.	GA.8050 Confidentiality	• Minor language and formatting changes	• Annual review with minor updates and formatting changes

Back to Agenda

3.	GA.8058 Salary Schedule	• This policy focuses solely on CalOptima's Salary Schedule and requirements under CalPERS regulations. • Attachment 1 – Salary Schedule has been revised in order to reflect recent changes, including the addition of new positions. A summary of the changes to the Salary Schedule is included for reference.	- Pursuant to CalPERS requirement, 2 CCR §570.5 CalOptima periodically updates the salary schedule to reflect current job titles and pay rates for each job position. - New Position: Creation of a new Job Title typically due to a change in the scope of a current position or the addition of a new level in a job family. (1 position)

Fiscal Impact
The recommended action to add one (1) new job title is a budgeted item under the Fiscal Year 2018-19 Operating Budget and has no additional fiscal impact.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Resolution No. 18-1004, Approve Revised CalOptima Human Resources Policies
2. Revised CalOptima Policies:
    a. GA.8032 Employee Dress Code (redlined and clean copies) with revised Attachment A
    b. GA.8050 Confidentiality (redlined and clean copies)
    c. GA.8058 Salary Schedule (redlined and clean copies) with revised Attachment A
3. Summary of Changes to Salary Schedule

/s/ Michael Schrader — **Authorized Signature**

9/26/2018 — **Date**

Back to Agenda

RESOLUTION NO. 18-1004

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

APPROVE UPDATED HUMAN RESOURCES POLICIES

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated Human Resources Policies: GA.8032: Employee Dress Code; GA.8050: Confidentiality; and GA.8058: Salary Schedule.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 4th day of October 2018.

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

Back to Agenda

Policy #: GA.8032
Title: **Employee Dress Code**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 01/05/12
Last Review Date: ~~11/03/16~~10/04/18
Last Revised Date: ~~11/03/16~~10/04/18

~~*Board Approved Policy*~~

I. PURPOSE

This policy sets forth the guidelines CalOptima employees shall follow to maintain appropriate attire at the workplace.

II. POLICY

A. CalOptima herein adopts a Business Casual Attire Dress Policy as the standard attire from Monday through Thursday. Employees must choose Business Casual Attire that communicates professionalism.

B. There may be ~~time~~times that Management ~~may require~~requires employees to dress in customary Business Professional Attire, including, but not limited to, when presenting to the Board of Directors, meeting with members of the business community, or representing the company at an outside community function.

C. All employees are required to sign the Dress Code Acknowledgement Form upon hire.

D. As a benefit, employees may dress in Casual Attire every Friday and every year during the following times, unless otherwise specified:

1. The week of Thanksgiving;
2. The period between Christmas and New Year's Day;
3. The period between Memorial Day and Labor Day; and
4. National Customer Service Week (First week of October).

E. Management within each department shall have the discretion to determine appropriate attire and grooming requirements for employees and independent contractors based upon job duties.

III. PROCEDURE

Responsible Party	Action
Employee	1. Sign the Dress Code Acknowledgment Form upon hire. 2. Adhere to the requirements in this policy.
Manager	1. Interpret and enforce dress and grooming standards in their area of responsibility. 2. If employee attire is inappropriate, the manager will address employee immediately.

Back to Agenda

Responsible Party	Action
Human Resources	1. Provide employees the Dress Code Policy and Agreement in the new hire packet. 2. File the Agreement in the employee's personnel file.

IV. ATTACHMENTS

A. Dress Code Acknowledgement Form

V. REFERENCES

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8000: Glossary of Terms

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 10/04/18: ~~—~~Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 11/03/16: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 05/01/14: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 01/05/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8032	Employee Dress Code	Administrative
Revised	02/01/2014	GA.8032	Employee Dress Code	Administrative
Revised	11/03/2016	GA.8032	Employee Dress Code	Administrative
Revised	10/04/2018	GA.8032	Employee Dress Code	Administrative

IX. GLOSSARY

Term	Definition
Business Casual Attire	Business Casual Attire includes suits, dress pants, dress shirts, dress shoes, dress sandals with a backstrap, sweaters, dresses, and skirts. Ties may be worn but are not required. All clothing should be compatible with a professional environment and clean, pressed, and in good repair. The height of heels should be suitable to the individual to prevent safety hazards~~.~~, and no more than three and one-half (3 1/2) inches in height. In all cases, management within each respective department will define "appropriate" Business Casual Attire. Business Casual Attire does not include: ▪ Jeans (or any type of denim or any color jeans or overalls) ▪ Spaghetti strap shirts, casual tank tops, halter tops, or tube tops ▪ See-through clothing ▪ Short skirts (where the length and/or fit is incompatible with a professional environment) ▪ Any type of shorts ~~(at or above the knee)~~ ▪ Casual sandals (such as flip flops, slide sandals or beach attire) ▪ Tennis or canvas shoes ▪ Any footwear without a back or backstrap ▪ Capri pants (unless part of a professional dress suit or ~~two~~ two-piece business outfit) ▪ Clothing displaying any written words or symbols, with the exception of CalOptima logo attire or brand names or symbols ▪ Clothing that reveals undergarments or parts of the body incompatible with a professional setting ▪ Hats, unless prior approval from Human Resources is given
CalOptima Logo Attire	CalOptima Logo Attire includes sweaters, dress shirts, polo shirts, or other shirts purchased through the ~~Human Resources Department~~Employee Activities Committee with CalOptima's logo displayed. Logo attire from any CalOptima program is allowed. These shirts must be partnered with dress pants or khaki pants in good condition. Logo attire is allowed Monday through Friday. CalOptima logo attire may not be worn with jeans~~, shorts~~ or capri pants from Monday through Thursday.

Term	Definition
Casual Attire	Casual Attire is a benefit permitted only on Fridays, unless otherwise specified. As with Business Casual Attire, Casual Attire should be compatible with a professional environment and neat in appearance and in good repair, with no tears or holes. Casual attire includes jeans, capri pants (loose and below the knee), casual sandals ~~(no flip flops),~~with a backstrap, tennis shoes, or other casual clothing in good condition. Leggings ~~or lycra slacks~~ are acceptable only when worn with a dress or long shirt that falls at least below the mid-thigh level. In all cases, management within each respective department will define "appropriate" casual attire. Casual Attire does not include: ▪ Any type of jogging or sweat suits/sweatpants ▪ ~~Halter tops~~ ▪ Spaghetti strap ~~shirts~~tops, casual tank tops, halter tops, or tube tops ▪ Casual sandals (such as flip flops, slide sandals or beach attire) ▪ Any footwear without a back or backstrap ▪ House slippers ▪ Yoga or workout pants ▪ See-through clothing ▪ Ripped jeans (including shredded jeans) ▪ ~~Shorts (at or above the knee)~~ ▪ Any type of shorts ▪ Clothing that exposes the stomach area or other parts of the body incompatible with a professional environment ▪ Clothing displaying any written words or symbols, with the exception of CalOptima logo attire, brand names or symbols, sports teams, or university/school/club names or logos ▪ Hats, unless prior approval from Human Resources is given

1

Policy #: GA.8032
Title: **Employee Dress Code**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 01/05/12
Last Review Date: 10/04/18
Last Revised Date: 10/04/18

I. PURPOSE

This policy sets forth the guidelines CalOptima employees shall follow to maintain appropriate attire at the workplace.

II. POLICY

A. CalOptima herein adopts a Business Casual Attire Dress Policy as the standard attire from Monday through Thursday. Employees must choose Business Casual Attire that communicates professionalism.

B. There may be times that Management requires employees to dress in customary Business Professional Attire, including, but not limited to, when presenting to the Board of Directors, meeting with members of the business community, or representing the company at an outside community function.

C. All employees are required to sign the Dress Code Acknowledgement Form upon hire.

D. As a benefit, employees may dress in Casual Attire every Friday and every year during the following times, unless otherwise specified:

1. The week of Thanksgiving;

2. The period between Christmas and New Year's Day;

3. The period between Memorial Day and Labor Day; and

4. National Customer Service Week (First week of October).

E. Management within each department shall have the discretion to determine appropriate attire and grooming requirements for employees and independent contractors based upon job duties.

III. PROCEDURE

Responsible Party	Action
Employee	1. Sign the Dress Code Acknowledgment Form upon hire. 2. Adhere to the requirements in this policy.
Manager	1. Interpret and enforce dress and grooming standards in their area of responsibility. 2. If employee attire is inappropriate, the manager will address employee immediately.

Responsible Party	Action
Human Resources	1. Provide employees the Dress Code Policy and Agreement in the new hire packet. 2. File the Agreement in the employee's personnel file.

IV. ATTACHMENTS

A. Dress Code Acknowledgement Form

V. REFERENCES

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8000: Glossary of Terms

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors
B. 11/03/16: Regular Meeting of the CalOptima Board of Directors
C. 05/01/14: Regular Meeting of the CalOptima Board of Directors
D. 01/05/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8032	Employee Dress Code	Administrative
Revised	02/01/2014	GA.8032	Employee Dress Code	Administrative
Revised	11/03/2016	GA.8032	Employee Dress Code	Administrative
Revised	10/04/2018	GA.8032	Employee Dress Code	Administrative

IX. GLOSSARY

Term	Definition
Business Casual Attire	Business Casual Attire includes suits, dress pants, dress shirts, dress shoes, dress sandals with a backstrap, sweaters, dresses, and skirts. Ties may be worn but are not required. All clothing should be compatible with a professional environment and clean, pressed, and in good repair. The height of heels should be suitable to the individual to prevent safety hazards, and no more than three and one-half (3 1/2) inches in height. In all cases, management within each respective department will define "appropriate" Business Casual Attire. Business Casual Attire does not include: ▪ Jeans (or any type of denim or any color jeans or overalls) ▪ Spaghetti strap shirts, casual tank tops, halter tops, or tube tops ▪ See-through clothing ▪ Short skirts (where the length and/or fit is incompatible with a professional environment) ▪ Any type of shorts ▪ Casual sandals (such as flip flops, slide sandals or beach attire) ▪ Tennis or canvas shoes ▪ Any footwear without a back or backstrap ▪ Capri pants (unless part of a professional dress suit or two-piece business outfit) ▪ Clothing displaying any written words or symbols, with the exception of CalOptima logo attire or brand names or symbols ▪ Clothing that reveals undergarments or parts of the body incompatible with a professional setting ▪ Hats, unless prior approval from Human Resources is given
CalOptima Logo Attire	CalOptima Logo Attire includes sweaters, dress shirts, polo shirts, or other shirts purchased through the Employee Activities Committee with CalOptima's logo displayed. Logo attire from any CalOptima program is allowed. These shirts must be partnered with dress pants or khaki pants in good condition. Logo attire is allowed Monday through Friday. CalOptima logo attire may not be worn with jeans or capri pants from Monday through Thursday.

Term	Definition
Casual Attire	Casual Attire is a benefit permitted only on Fridays, unless otherwise specified. As with Business Casual Attire, Casual Attire should be compatible with a professional environment and neat in appearance and in good repair, with no tears or holes. Casual attire includes jeans, capri pants (loose and below the knee), casual sandals with a backstrap, tennis shoes, or other casual clothing in good condition. Leggings are acceptable only when worn with a dress or long shirt that falls at least below the mid-thigh level. In all cases, management within each respective department will define "appropriate" casual attire. Casual Attire does not include: ▪ Any type of jogging or sweat suits/sweatpants ▪ Spaghetti strap tops, casual tank tops, halter tops, or tube tops ▪ Casual sandals (such as flip flops, slide sandals or beach attire) ▪ Any footwear without a back or backstrap ▪ House slippers ▪ Yoga or workout pants ▪ See-through clothing ▪ Ripped jeans (including shredded jeans) ▪ Any type of shorts ▪ Clothing that exposes the stomach area or other parts of the body incompatible with a professional environment ▪ Clothing displaying any written words or symbols, with the exception of CalOptima logo attire, brand names or symbols, sports teams, or university/school/club names or logos ▪ Hats, unless prior approval from Human Resources is given

1

CalOptima has adopted a Business Casual Attire Dress Policy as the standard attire Monday through Thursday. Employees must choose Business Casual Attire that communicates professionalism. There may be times that Management may require employees to dress in customary Business Professional Attire, including, but not limited to, when presenting to the Board of Directors, meeting with members of the business community or representing the company at an outside community function.

The purpose of this memorandum is to obtain acknowledgement from the employee that they received the Employee Dress Code Policy and agree to abide by and cooperate with the requirements and expectations.

Business Casual Attire:

Business casual attire includes suits, dress pants, dress shirts, dress shoes, dress sandals, sweaters, dresses and skirts. Ties may be worn but are not required. All clothing should be clean, pressed, and in good repair. The height of heels should be suitable to the individual to prevent safety hazards. In all cases, management within each respective department will define "appropriate" Business Casual Attire. Business Casual Attire does not include: jeans (or any type of denim or any color jeans), spaghetti strap shirts, see through clothing, low cut blouses, short skirts, any type of shorts (at or above the knee), casual sandals (such as flip flops or beach attire), tennis shoes, Uggs, Capri pants (unless part of a professional dress suit or two piece business outfit), clothing displaying any written words or symbols, with the exception of CalOptima logo attire or brand names or symbols, clothing that reveals undergarments or parts of the body incompatible with a professional setting, and hats (unless prior approval from Human Resources is given). Leggings or Lycra form fitting pants are not allowed. In addition, we ask that you not wear any distracting, offensive, low cut and revealing clothes.

CalOptima Logo Attire:

CalOptima Logo Attire includes dress shirts, polo shirts, or other shirts purchased through the Employee Activities Committee with CalOptima's logo displayed. Logo attire from any CalOptima program is allowed. These shirts must be partnered with dress pants or khaki pants in good condition. Logo attire is allowed Monday through Friday. CalOptima Logo Attire may not be worn with jeans, shorts or capri pants from Monday through Thursday.

Casual Attire:

Casual Attire is a benefit permitted only on Fridays, unless otherwise specified. As with Business Casual Attire, Casual Attire should be neat in appearance and in good repair, with no tears or holes. Casual Attire includes jeans, Capri pants (loose and below the knee), casual sandals (no flip flops), tennis shoes or other casual clothing in good condition. Leggings or Lycra slacks are acceptable only when worn with a dress or long shirt that falls at least below the mid thigh level. In all cases, management within each respective department will define "appropriate" casual attire. Casual Attire does not include: any type of jogging or sweat suits/sweatpants, halter tops, spaghetti strap shirts, see through clothing, ripped jeans, shorts (at or above the knee), clothing that exposes the stomach area or other parts of the body incompatible with a professional environment, clothing displaying any written words or symbols, with the exception of CalOptima logo attire, brand names or symbols, sports teams, or university/school/club names or logos, and hats (unless prior approval from Human Resources is given.

As a benefit, employees may dress in Casual Attire every Friday and every year during the following times, unless otherwise specified: the week of Thanksgiving, the period between Christmas and New Year's Day, the period between Memorial Day and Labor Day, and National Customer Service Week (first week of October).

Managers are responsible for interpreting and enforcing dress and grooming standards in their area of responsibility and within the guidelines of CalOptima's Employee Dress Code Policy. Any employee whose appearance does not meet these standards will be counseled by his/her manager. If the appearance is unduly distracting, unsafe, or inappropriate, the employee may be sent home to correct the problem. Repeated disregard for this dress policy may result in disciplinary action up to and including termination.

CalOptima Dress Code Outline

Business Casual Attire (Monday—Thursday)	Casual Attire (Friday, other exceptions)	Unacceptable Attire (never appropriate)
☐ Suits ☐ Dress pants ☐ Dress shirts ☐ Dress sandals ☐ Sweaters ☐ Dresses and skirts ☐ Ties (may be worn but are not required) ☐ CalOptima logo shirts paired with dress khaki pants ☐ Capri pants (only when worn as part of a professional dress suit or two-piece business outfit)	☐ Jeans ☐ Capri pants (loose and below the knee) ☐ Casual sandals (no flip-flops) ☐ Tennis shoes ☐ Leggings or Lycra form-fitting pants (acceptable only when worn with a dress or long shirt that falls at least below mid-thigh) ☐ Other casual clothing in good condition	☒ Any type of jogging or sweat suits/ sweatpants ☒ Halter tops ☒ Flip-Flops ☒ Spaghetti strap shirts ☒ Clothing that reveals undergarments or parts of the body incompatible with a professional setting ☒ Ugg-type shoes or boots ☒ Any type of shorts (at or above the knee) ☒ short skirts ☒ clothing with writing or symbols that contain profanity, or that advocate or are associated with violence against any persons ☒ Hats (unless employee obtains prior approval from HR)

~~GA.8032 Employee Dress Code Policy~~ Acknowledgement of Receipt:

I acknowledge that I have received and reviewed a copy of CalOptima Policy GA.~~-~~8032:~~'s~~ Employee Dress Code ~~Policy~~, and I agree to abide by and cooperate with the above requirements and expectations.

_____
Employee Signature

_____
Date

Acknowledgement of Receipt:

I acknowledge that I have received and reviewed a copy of CalOptima Policy GA.8032: Employee Dress Code , and I agree to abide by and cooperate with the above requirements and expectations.

_____
Employee Signature

_____
Date

Policy #: GA.8050
Title: **Confidentiality**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 02/01/14
Last Review Date: ~~12/01/16~~
Last Revised Date: 10/04/18
~~12/01/16~~
10/04/18

~~*Board Approved Policy*~~

I. PURPOSE

This policy outlines CalOptima's guidelines for protecting proprietary, private, and confidential information.

II. POLICY

A. CalOptima Board members, executive staff, employees, contractors, interns, volunteers, and temporary employees (referred to herein collectively as "Employees") shall not disclose, divulge, or make accessible proprietary, private, and/or confidential information belonging to, or obtained through the Employee's affiliation with, CalOptima to any person, including but not limited to, relatives, friends, and business and professional associates, other than to persons who have a legitimate business need for such information and to whom CalOptima has authorized disclosure. This obligation includes making sure ~~electronic~~ proprietary, private, and confidential information is secure~~,~~ (whether maintained in electronic or other format), taking precautions to secure files, and following all federal, state, and local laws and regulations.

B. Proprietary information includes all information obtained by Employees during the course of their work with or at CalOptima, including, but not limited to, intellectual property, computer software, and provider identification numbers. Private information includes, but is not limited to, any information related to a person's health, employment application, residence address, testing scores, personnel reviews, social security number, etc. Confidential information is any information that is not known generally to the public, including, but not limited to, Protected Health Information (PHI), personnel files, provider rates, the Department of Health Care Services (DHCS) reimbursement rates, and any other information that may exist in contracts, administrative files, personnel records, computer records, computer programs, and financial data.

C. Inappropriate use, unauthorized copy and transfer, attempted destruction, or the destruction or disclosure of confidential, private, or proprietary information obtained through the Employee's affiliation with CalOptima will subject an Employee to discipline, up to and including termination, and possible legal recourse.

III. PROCEDURE

A. CalOptima Employees shall:

1. Use proprietary, private, and/or confidential information solely for the purpose of performing services as a trustee, or ~~employee~~Employee, of CalOptima;

2. Exercise good judgment and care at all times to avoid unauthorized, or improper, disclosures of proprietary, private, and/or confidential information; and

3. Adhere to all CalOptima compliance and Health Insurance Portability and Accountability Act (HIPAA) policies, in accordance with CalOptima Policies IS.1101: EPHI Physical Controls, IS.1201: EPHI Technical Safeguards - Access Controls, IS.1202: EPHI Technical Safeguards - Data Controls, GA.5005a: Use of Technology Resources, and IS.1301: Security of Workforce Access to EPHI.

B. Conversations in public places, such as restaurants, elevators, restrooms, hallways, lobbies, and while traveling via public transportation, should be limited to matters that do not pertain to information of a sensitive, proprietary, private, and/ or confidential nature. In addition, Employees must be sensitive to the risk of inadvertent disclosure and should refrain from leaving proprietary, private, and/or confidential information on desks, workspaces, personal computers, cars, or otherwise in plain view of unauthorized persons, and Employees shall refrain from the use of speaker phones to discuss confidential information if the conversation could be heard by unauthorized persons.

C. ~~CalOptima employees~~Employees may receive more specific requirements regarding the confidentiality of the information. In brief summary, Employees and individuals affiliated with CalOptima are subject to various confidentiality provisions such as:

1. Public Assistance Recipients: The identity of an individual receiving public services/assistance is protected by federal law. Medi-Cal is a form of public assistance and providing information regarding an individual's eligibility is limited only to purposes of service delivery. Only those designated individuals responsible for verifying eligibility to providers should be providing such information and only to authorized recipients.

2. Medical Records: Medical condition and treatment records are confidential between the treating healthcare Provider and Member. Such information is protected under California and federal law. When authorized, such records may be subject to review by qualified professionals involved in CalOptima's responsibilities related to such functions as claims, utilization review, quality assurance, grievance appeals, etc. Any ~~knowledge~~information obtained in this regard must be kept confidential and may not be disclosed to unauthorized persons.

3. Special Health Conditions: Information related to the identity of individuals receiving treatment with certain health conditions carry further confidentiality protection, e.g., AIDS, substance abuse, mental illness, or venereal disease.

4. Special Categories: Other conditions, or circumstances, are covered by special confidentiality provisions, e.g., minors, victims of abuse, etc.

5. Rates: The rates paid to CalOptima by the Department of Health Care Services (DHCS) and the rates CalOptima pays to its contractors/providers are confidential under state and federal law.

D. HIPAA requires CalOptima, its Employees, and its agents to comply with the following standards to protect the privacy of an individual's PHI. PHI is any individually identifiable health information,

including demographic information. CalOptima is committed to ensuring the privacy and security of Member information, and Employees shall comply with applicable laws and CalOptima policies and procedures to protect and maintain the confidentiality of PHI as outlined below:

1. General Use: PHI pertaining to Members may only be used to perform functions, activities, or services for the purpose of treatment, payment, or health care operations, unless otherwise authorized by the Member, or required by law. In addition, use or disclosure of PHI should be limited to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

2. Unacceptable Use: PHI shall not be used for personal benefit, or for the benefit of any other person or entity. Divulging the Medi-Cal status, or other PHI, of a Member to unauthorized recipients is prohibited.

3. Privacy and Security Safeguards: CalOptima is required to have in place administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI. These safeguards may include, but ~~is~~are not limited to, physically securing PHI in paper form and encrypting PHI in electronic form.

E. At the end of a Board member's term in office, or upon the termination of an Employee's relationship with CalOptima, he or she shall immediately return all documents, papers, electronic files, and other materials, regardless of medium, which may contain or be derived from confidential, private or proprietary information in his or her possession.

F. Any individual covered by this policy who violates its provisions shall be subject to discipline and/or separation from service, or affiliation, with CalOptima as well as possible civil and/or criminal liability. The restrictions of this policy also pertain to any disclosure or use of confidential, private, or proprietary information after leaving affiliation with CalOptima.

G. CalOptima shall provide new hires with this ~~policy~~Policy.

1. All Employees are required to sign an acknowledgment agreeing to comply with this ~~policy~~Policy.

2. Failure to sign such acknowledgment may result in disciplinary action, up to and including possible termination.

IV. ATTACHMENTS

~~A. CalOptima Code of Conduct~~
Not Applicable

V. REFERENCES

A. CalOptima Code of Conduct
B. CalOptima Compliance Plan
~~B.~~C. CalOptima Employee Handbook
~~C.~~D. CalOptima Policy GA.8000: Glossary of Terms
~~D.~~E. CalOptima Policy GA.5005.a: Use of Technology Resources
~~E.~~F. CalOptima Policy IS.1101: EPHI Physical Controls

~~F.~~G. CalOptima Policy IS.1201: EPHI Technical Safeguards - Access Controls
~~G.~~H. CalOptima Policy IS.1202: EPHI Technical Safeguards - Data Controls
~~H.~~I. CalOptima Policy IS.1301: Security of Workforce Access to EPHI
J. Confidentiality Statement

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/01/16: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 05/01/14: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/01/2014	GA.8050	Confidentiality	Administrative
Revised	12/01/2016	GA.8050	Confidentiality	Administrative
Revised	10/04/2018	GA.8050	Confidentiality	Administrative

IX. GLOSSARY

Term	Definition
Employee	For purposes of this policy, include, but are not limited to, all full-time and part-time regular CalOptima employees, all temporary employees, volunteers, interns, CalOptima Board members, and applicable contractors and consultants.
Health Insurance Portability and Accountability Act	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.
Medical Record	Any single or complete record kept or required to be kept 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	An enrollee-beneficiary of a CalOptima program.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by ~~Cal Optima~~CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

Policy #: GA.8050
Title: **Confidentiality**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader

Effective Date: 02/01/14
Last Review Date: 10/04/18
Last Revised Date: 10/04/18

I. PURPOSE

This policy outlines CalOptima's guidelines for protecting proprietary, private, and confidential information.

II. POLICY

A. CalOptima Board members, executive staff, employees, contractors, interns, volunteers, and temporary employees (referred to herein collectively as "Employees") shall not disclose, divulge, or make accessible proprietary, private, and/or confidential information belonging to, or obtained through the Employee's affiliation with, CalOptima to any person, including but not limited to, relatives, friends, and business and professional associates, other than to persons who have a legitimate business need for such information and to whom CalOptima has authorized disclosure. This obligation includes making sure proprietary, private, and confidential information is secure (whether maintained in electronic or other format), taking precautions to secure files, and following all federal, state, and local laws and regulations.

B. Proprietary information includes all information obtained by Employees during the course of their work with or at CalOptima, including, but not limited to, intellectual property, computer software, and provider identification numbers. Private information includes, but is not limited to, any information related to a person's health, employment application, residence address, testing scores, personnel reviews, social security number, etc. Confidential information is any information that is not known generally to the public, including, but not limited to, Protected Health Information (PHI), personnel files, provider rates, the Department of Health Care Services (DHCS) reimbursement rates, and any other information that may exist in contracts, administrative files, personnel records, computer records, computer programs, and financial data.

C. Inappropriate use, unauthorized copy and transfer, attempted destruction, or the destruction or disclosure of confidential, private, or proprietary information obtained through the Employee's affiliation with CalOptima will subject an Employee to discipline, up to and including termination, and possible legal recourse.

III. PROCEDURE

A. CalOptima Employees shall:

1. Use proprietary, private, and/or confidential information solely for the purpose of performing services as a trustee, or Employee, of CalOptima;

2. Exercise good judgment and care at all times to avoid unauthorized, or improper, disclosures of proprietary, private, and/or confidential information; and

3. Adhere to all CalOptima compliance and Health Insurance Portability and Accountability Act (HIPAA) policies, in accordance with CalOptima Policies IS.1101: EPHI Physical Controls, IS.1201: EPHI Technical Safeguards - Access Controls, IS.1202: EPHI Technical Safeguards - Data Controls, GA.5005a: Use of Technology Resources, and IS.1301: Security of Workforce Access to EPHI.

B. Conversations in public places, such as restaurants, elevators, restrooms, hallways, lobbies, and while traveling via public transportation, should be limited to matters that do not pertain to information of a sensitive, proprietary, private, and/ or confidential nature. In addition, Employees must be sensitive to the risk of inadvertent disclosure and should refrain from leaving proprietary, private, and/or confidential information on desks, workspaces, personal computers, cars, or otherwise in plain view of unauthorized persons, and Employees shall refrain from the use of speaker phones to discuss confidential information if the conversation could be heard by unauthorized persons.

C. Employees may receive more specific requirements regarding the confidentiality of the information. In brief summary, Employees and individuals affiliated with CalOptima are subject to various confidentiality provisions such as:

1. Public Assistance Recipients: The identity of an individual receiving public services/assistance is protected by federal law. Medi-Cal is a form of public assistance and providing information regarding an individual's eligibility is limited only to purposes of service delivery. Only those designated individuals responsible for verifying eligibility to providers should be providing such information and only to authorized recipients.

2. Medical Records: Medical condition and treatment records are confidential between the treating healthcare Provider and Member. Such information is protected under California and federal law. When authorized, such records may be subject to review by qualified professionals involved in CalOptima's responsibilities related to such functions as claims, utilization review, quality assurance, grievance appeals, etc. Any information obtained in this regard must be kept confidential and may not be disclosed to unauthorized persons.

3. Special Health Conditions: Information related to the identity of individuals receiving treatment with certain health conditions carry further confidentiality protection, e.g., AIDS, substance abuse, mental illness, or venereal disease.

4. Special Categories: Other conditions, or circumstances, are covered by special confidentiality provisions, e.g., minors, victims of abuse, etc.

5. Rates: The rates paid to CalOptima by the Department of Health Care Services (DHCS) and the rates CalOptima pays to its contractors/providers are confidential under state and federal law.

D. HIPAA requires CalOptima, its Employees, and its agents to comply with the following standards to protect the privacy of an individual's PHI. PHI is any individually identifiable health information, including demographic information. CalOptima is committed to ensuring the privacy and security of Member information, and Employees shall comply with applicable laws and CalOptima policies and procedures to protect and maintain the confidentiality of PHI as outlined below:

1. General Use: PHI pertaining to Members may only be used to perform functions, activities, or services for the purpose of treatment, payment, or health care operations, unless otherwise authorized by the Member, or required by law. In addition, use or disclosure of PHI should be limited to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

2. Unacceptable Use: PHI shall not be used for personal benefit, or for the benefit of any other person or entity. Divulging the Medi-Cal status, or other PHI, of a Member to unauthorized recipients is prohibited.

3. Privacy and Security Safeguards: CalOptima is required to have in place administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI. These safeguards may include, but are not limited to, physically securing PHI in paper form and encrypting PHI in electronic form.

E. At the end of a Board member's term in office, or upon the termination of an Employee's relationship with CalOptima, he or she shall immediately return all documents, papers, electronic files, and other materials, regardless of medium, which may contain or be derived from confidential, private or proprietary information in his or her possession.

F. Any individual covered by this policy who violates its provisions shall be subject to discipline and/or separation from service, or affiliation, with CalOptima as well as possible civil and/or criminal liability. The restrictions of this policy also pertain to any disclosure or use of confidential, private, or proprietary information after leaving affiliation with CalOptima.

G. CalOptima shall provide new hires with this Policy.

1. All Employees are required to sign an acknowledgment agreeing to comply with this Policy.

2. Failure to sign such acknowledgment may result in disciplinary action, up to and including possible termination.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Code of Conduct
B. CalOptima Compliance Plan
C. CalOptima Employee Handbook
D. CalOptima Policy GA.8000: Glossary of Terms
E. CalOptima Policy GA.5005.a: Use of Technology Resources
F. CalOptima Policy IS.1101: EPHI Physical Controls
G. CalOptima Policy IS.1201: EPHI Technical Safeguards - Access Controls
H. CalOptima Policy IS.1202: EPHI Technical Safeguards - Data Controls
I. CalOptima Policy IS.1301: Security of Workforce Access to EPHI
J. Confidentiality Statement

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors
B. 12/01/16: Regular Meeting of the CalOptima Board of Directors
C. 05/01/14: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/01/2014	GA.8050	Confidentiality	Administrative
Revised	12/01/2016	GA.8050	Confidentiality	Administrative
Revised	10/04/2018	GA.8050	Confidentiality	Administrative

IX. GLOSSARY

Term	Definition
Employee	For purposes of this policy, include, but are not limited to, all full-time and part-time regular CalOptima employees, all temporary employees, volunteers, interns, CalOptima Board members, and applicable contractors and consultants.
Health Insurance Portability and Accountability Act	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.
Medical Record	Any single or complete record kept or required to be kept 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	An enrollee-beneficiary of a CalOptima program.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

Policy #:	GA.8058
Title:	**Salary Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/14
Last Review Date:	~~09~~10/~~06~~0
Last Revised Date:	4/18
	~~09~~10/~~06~~0
	4/18

~~*Board Approved Policy*~~

I. PURPOSE

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

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

II. POLICY

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

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

2. Identification of position titles for every employee position;

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

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

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

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

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

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

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

III. PROCEDURE

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

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

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

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

IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of ~~09~~10/0~~6~~4/18)

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 09/06/18: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 02/01/18: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 11/02/17: Regular Meeting of the CalOptima Board of Directors
~~D.~~E. 09/07/17: Regular Meeting of the CalOptima Board of Directors
~~E.~~F. 08/03/17: Regular Meeting of the CalOptima Board of Directors
~~F.~~G. 06/01/17: Regular Meeting of the CalOptima Board of Directors
~~G.~~H. 05/04/17: Regular Meeting of the CalOptima Board of Directors
~~H.~~I. 03/02/17: Regular Meeting of the CalOptima Board of Directors
~~I.~~J. 12/01/16: Regular Meeting of the CalOptima Board of Directors
~~J.~~K. 11/03/16: Regular Meeting of the CalOptima Board of Directors
~~K.~~L. 10/06/16: Regular Meeting of the CalOptima Board of Directors
~~L.~~M. 09/01/16: Regular Meeting of the CalOptima Board of Directors
~~M.~~N. 08/04/16: Regular Meeting of the CalOptima Board of Directors

~~N.~~O. 06/02/16: Regular Meeting of the CalOptima Board of Directors
~~O.~~P. 03/03/16: Regular Meeting of the CalOptima Board of Directors
~~P.~~Q. 12/03/15: Regular Meeting of the CalOptima Board of Directors
~~Q.~~R. 10/01/15: Regular Meeting of the CalOptima Board of Directors
~~R.~~S. 06/04/15: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

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

IX. GLOSSARY

Not Applicable

Policy #:	GA.8058
Title:	**Salary Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/14
Last Review Date:	10/04/18
Last Revised Date:	10/04/18

I. PURPOSE

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

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

II. POLICY

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

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

2. Identification of position titles for every employee position;

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

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

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

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

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

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

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

III. PROCEDURE

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

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

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

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

IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of 10/04/18)

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors
B. 09/06/18: Regular Meeting of the CalOptima Board of Directors
C. 02/01/18: Regular Meeting of the CalOptima Board of Directors
D. 11/02/17: Regular Meeting of the CalOptima Board of Directors
E. 09/07/17: Regular Meeting of the CalOptima Board of Directors
F. 08/03/17: Regular Meeting of the CalOptima Board of Directors
G. 06/01/17: Regular Meeting of the CalOptima Board of Directors
H. 05/04/17: Regular Meeting of the CalOptima Board of Directors
I. 03/02/17: Regular Meeting of the CalOptima Board of Directors
J. 12/01/16: Regular Meeting of the CalOptima Board of Directors
K. 11/03/16: Regular Meeting of the CalOptima Board of Directors
L. 10/06/16: Regular Meeting of the CalOptima Board of Directors
M. 09/01/16: Regular Meeting of the CalOptima Board of Directors
N. 08/04/16: Regular Meeting of the CalOptima Board of Directors
O. 06/02/16: Regular Meeting of the CalOptima Board of Directors
P. 03/03/16: Regular Meeting of the CalOptima Board of Directors

Q. 12/03/15: Regular Meeting of the CalOptima Board of Directors
R. 10/01/15: Regular Meeting of the CalOptima Board of Directors
S. 06/04/15: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

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

IX. GLOSSARY

Not Applicable

CalOptima - Annual Base Salary Schedule - Revised October 4, 2018
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Accountant	K	39	$47,112	$61,360	$75,504	
	Accountant Int	L	634	$54,288	$70,512	$86,736	
	Accountant Sr	M	68	$62,400	$81,120	$99,840	
	Accounting Clerk	I	334	$37,128	$46,384	$55,640	
	Actuarial Analyst	L	558	$54,288	$70,512	$86,736	
	Actuarial Analyst Sr	M	559	$62,400	$81,120	$99,840	
	Actuary	O	357	$82,576	$107,328	$131,976	
	Administrative Assistant	H	19	$33,696	$42,224	$50,648	
	Analyst	K	562	$47,112	$61,360	$75,504	
	Analyst Int	L	563	$54,288	$70,512	$86,736	
	Analyst Sr	M	564	$62,400	$81,120	$99,840	
	Applications Analyst	K	232	$47,112	$61,360	$75,504	
	Applications Analyst Int	L	233	$54,288	$70,512	$86,736	
	Applications Analyst Sr	M	298	$62,400	$81,120	$99,840	
	Associate Director Customer Service	O	593	$82,576	$107,328	$131,976	
	Associate Director Information Services	Q	557	$114,400	$154,440	$194,480	
	Associate Director Provider Network	O	647	$82,576	$107,328	$131,976	
	Auditor	K	565	$47,112	$61,360	$75,504	
	Auditor Sr	L	566	$54,288	$70,512	$86,736	
	Behavioral Health Manager	N	383	$71,760	$93,184	$114,712	
	Biostatistics Manager	N	418	$71,760	$93,184	$114,712	
	Board Services Specialist	J	435	$40,976	$53,352	$65,624	
	Business Analyst	J	40	$40,976	$53,352	$65,624	
	Business Analyst Sr	M	611	$62,400	$81,120	$99,840	
	Business Systems Analyst Sr	M	69	$62,400	$81,120	$99,840	
	Buyer	J	29	$40,976	$53,352	$65,624	
	Buyer Int	K	49	$47,112	$61,360	$75,504	
	Buyer Sr	L	67	$54,288	$70,512	$86,736	
	Care Manager	M	657	$62,400	$81,120	$99,840	
	Care Transition Intervention Coach (RN)	N	417	$71,760	$93,184	$114,712	
	Certified Coder	K	399	$47,112	$61,360	$75,504	
	Certified Coding Specialist	K	639	$47,112	$61,360	$75,504	
	Certified Coding Specialist Sr	L	640	$54,288	$70,512	$86,736	
	Change Control Administrator	L	499	$54,288	$70,512	$86,736	
	Change Control Administrator Int	M	500	$62,400	$81,120	$99,840	
	Change Management Analyst Sr	N	465	$71,760	$93,184	$114,712	
**	Chief Counsel	T	132	$197,704	$266,968	$336,024	
**	Chief Executive Officer	V	138	$319,740	$431,600	$543,600	
**	Chief Financial Officer	U	134	$237,224	$320,216	$403,312	
**	Chief Information Officer	T	131	$197,704	$266,968	$336,024	
**	Chief Medical Officer	U	137	$237,224	$320,216	$403,312	
**	Chief Operating Officer	U	136	$237,224	$320,216	$403,312	
	Claims - Lead	J	574	$40,976	$53,352	$65,624	
	Claims Examiner	H	9	$33,696	$42,224	$50,648	
	Claims Examiner - Lead	J	236	$40,976	$53,352	$65,624	
	Claims Examiner Sr	I	20	$37,128	$46,384	$55,640	
	Claims QA Analyst	I	28	$37,128	$46,384	$55,640	
	Claims QA Analyst Sr.	J	540	$40,976	$53,352	$65,624	
	Claims Recovery Specialist	I	283	$37,128	$46,384	$55,640	
	Claims Resolution Specialist	I	262	$37,128	$46,384	$55,640	
	Clerk of the Board	O	59	$82,576	$107,328	$131,976	
	Clinical Auditor	M	567	$62,400	$81,120	$99,840	
	Clinical Auditor Sr	N	568	$71,760	$93,184	$114,712	
	Clinical Documentation Specialist (RN)	O	641	$82,576	$107,328	$131,976	
	Clinical Pharmacist	P	297	$95,264	$128,752	$162,032	
	Clinical Systems Administrator	M	607	$62,400	$81,120	$99,840	
	Clinician (Behavioral Health)	M	513	$62,400	$81,120	$99,840	
	Communications Specialist	J	188	$40,976	$53,352	$65,624	
	Community Partner	K	575	$47,112	$61,360	$75,504	
	Community Partner Sr	L	612	$54,288	$70,512	$86,736	
	Community Relations Specialist	J	288	$40,976	$53,352	$65,624	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised October 4, 2018
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Community Relations Specialist Sr	K	646	$47,112	$61,360	$75,504	
	Compliance Claims Auditor	K	222	$47,112	$61,360	$75,504	
	Compliance Claims Auditor Sr	L	279	$54,288	$70,512	$86,736	
	Contract Administrator	M	385	$62,400	$81,120	$99,840	
	Contracts Manager	N	207	$71,760	$93,184	$114,712	
	Contracts Specialist	K	257	$47,112	$61,360	$75,504	
	Contracts Specialist Int	L	469	$54,288	$70,512	$86,736	
	Contracts Specialist Sr	M	331	$62,400	$81,120	$99,840	
*	Controller	Q	464	$114,400	$154,440	$194,480	
	Credentialing Coordinator	J	41	$40,976	$53,352	$65,624	
	Credentialing Coordinator - Lead	J	510	$40,976	$53,352	$65,624	
	Customer Service Coordinator	J	182	$40,976	$53,352	$65,624	
	Customer Service Rep	H	5	$33,696	$42,224	$50,648	
	Customer Service Rep - Lead	J	482	$40,976	$53,352	$65,624	
	Customer Service Rep Sr	I	481	$37,128	$46,384	$55,640	
	Data Analyst	K	337	$47,112	$61,360	$75,504	
	Data Analyst Int	L	341	$54,288	$70,512	$86,736	
	Data Analyst Sr	M	342	$62,400	$81,120	$99,840	
	Data and Reporting Analyst - Lead	O	654	$82,576	$107,328	$131,976	
	Data Entry Tech	F	3	$27,872	$34,840	$41,808	
	Data Warehouse Architect	O	363	$82,576	$107,328	$131,976	
	Data Warehouse Programmer/Analyst	O	364	$82,576	$107,328	$131,976	
	Data Warehouse Project Manager	O	362	$82,576	$107,328	$131,976	
	Data Warehouse Reporting Analyst	N	412	$71,760	$93,184	$114,712	
	Data Warehouse Reporting Analyst Sr	O	522	$82,576	$107,328	$131,976	
	Database Administrator	M	90	$62,400	$81,120	$99,840	
	Database Administrator Sr	O	179	$82,576	$107,328	$131,976	
**	Deputy Chief Counsel	S	160	$164,736	$222,352	$280,072	
**	Deputy Chief Medical Officer	T	561	$197,704	$266,968	$336,024	
*	Director Accounting	P	122	$95,264	$128,752	$162,032	
*	Director Applications Management	R	170	$137,280	$185,328	$233,376	
*	Director Audit & Oversight	Q	546	$114,400	$154,440	$194,480	
*	Director Behavioral Health Services	P	392	$95,264	$128,752	$162,032	
*	Director Budget and Procurement	Q	527	$114,400	$154,440	$194,480	
*	Director Business Development	P	351	$95,264	$128,752	$162,032	
*	Director Business Integration	Q	543	$114,400	$154,440	$194,480	
*	Director Case Management	Q	318	$114,400	$154,440	$194,480	
*	Director Claims Administration	P	112	$95,264	$128,752	$162,032	
*	Director Clinical Outcomes	Q	602	$114,400	$154,440	$194,480	
*	Director Clinical Pharmacy	R	129	$137,280	$185,328	$233,376	
*	Director Coding Initiatives	P	375	$95,264	$128,752	$162,032	
*	Director Communications	P	361	$95,264	$128,752	$162,032	
*	Director Community Relations	P	292	$95,264	$128,752	$162,032	
*	Director Configuration & Coding	Q	596	$114,400	$154,440	$194,480	
*	Director Contracting	P	184	$95,264	$128,752	$162,032	
*	Director COREC	Q	369	$114,400	$154,440	$194,480	
*	Director Customer Service	P	118	$95,264	$128,752	$162,032	
*	Director Electronic Business	P	358	$95,264	$128,752	$162,032	
*	Director Enterprise Analytics	Q	520	$114,400	$154,440	$194,480	
*	Director Facilities	P	428	$95,264	$128,752	$162,032	
*	Director Finance & Procurement	P	157	$95,264	$128,752	$162,032	
*	Director Financial Analysis	R	374	$137,280	$185,328	$233,376	
*	Director Financial Compliance	P	460	$95,264	$128,752	$162,032	
*	Director Fraud Waste & Abuse and Privacy	Q	581	$114,400	$154,440	$194,480	
*	Director Government Affairs	P	277	$95,264	$128,752	$162,032	
*	Director Grievance & Appeals	P	528	$95,264	$128,752	$162,032	
*	Director Health Education & Disease Management	Q	150	$114,400	$154,440	$194,480	
*	Director Health Services	Q	328	$114,400	$154,440	$194,480	
*	Director Human Resources	Q	322	$114,400	$154,440	$194,480	
*	Director Information Services	R	547	$137,280	$185,328	$233,376	
*	Director Long Term Support Services	Q	128	$114,400	$154,440	$194,480	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised October 4, 2018
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
*	Director Medi-Cal Plan Operations	P	370	$95,264	$128,752	$162,032	
*	Director Network Management	P	125	$95,264	$128,752	$162,032	
*	Director OneCare Operations	P	425	$95,264	$128,752	$162,032	
*	Director Organizational Training & Education	P	579	$95,264	$128,752	$162,032	
*	Director PACE Program	Q	449	$114,400	$154,440	$194,480	
*	Director Process Excellence	Q	447	$114,400	$154,440	$194,480	
*	Director Program Implementation	Q	489	$114,400	$154,440	$194,480	
*	Director Project Management	Q	447	$114,400	$154,440	$194,480	
*	Director Provider Data Quality	Q	655	$114,400	$154,440	$194,480	
*	Director Provider Services	P	597	$95,264	$128,752	$162,032	
*	Director Public Policy	P	459	$95,264	$128,752	$162,032	
*	Director Quality (LTSS)	Q	613	$114,400	$154,440	$194,480	
*	Director Quality Analytics	Q	591	$114,400	$154,440	$194,480	
*	Director Quality Improvement	Q	172	$114,400	$154,440	$194,480	
*	Director Regulatory Affairs and Compliance	Q	625	$114,400	$154,440	$194,480	
*	Director Strategic Development	P	121	$95,264	$128,752	$162,032	
*	Director Systems Development	R	169	$137,280	$185,328	$233,376	
*	Director Utilization Management	Q	265	$114,400	$154,440	$194,480	
	Disease Management Coordinator	M	70	$62,400	$81,120	$99,840	
	Disease Management Coordinator - Lead	M	472	$62,400	$81,120	$99,840	
	EDI Project Manager	O	403	$82,576	$107,328	$131,976	
	Enrollment Coordinator (PACE)	K	441	$47,112	$61,360	$75,504	
	Enterprise Analytics Manager	P	582	$95,264	$128,752	$162,032	
	Executive Assistant	K	339	$47,112	$61,360	$75,504	
	Executive Adminstrative Services Manager	M	663	$62,400	$81,120	$99,840	
**	Executive Director Clinical Operations	S	501	$164,736	$222,352	$280,072	
**	Executive Director Compliance	S	493	$164,736	$222,352	$280,072	
**	Executive Director Human Resources	S	494	$164,736	$222,352	$280,072	
**	Executive Director Network Operations	S	632	$164,736	$222,352	$280,072	
**	Executive Director Operations	S	276	$164,736	$222,352	$280,072	
**	Executive Director Program Implementation	S	490	$164,736	$222,352	$280,072	
**	Executive Director Public Affairs	S	290	$164,736	$222,352	$280,072	
**	Executive Director Quality Analytics	S	601	$164,736	$222,352	$280,072	
**	Executive Director, Behavioral Health Integration	S	614	$164,736	$222,352	$280,072	
	Facilities & Support Services Coord - Lead	J	631	$40,976	$53,352	$65,624	
	Facilities & Support Services Coordinator	J	10	$40,976	$53,352	$65,624	
	Facilities Coordinator	J	438	$40,976	$53,352	$65,624	
	Financial Analyst	L	51	$54,288	$70,512	$86,736	
	Financial Analyst Sr	M	84	$62,400	$81,120	$99,840	
	Financial Reporting Analyst	L	475	$54,288	$70,512	$86,736	
	Gerontology Resource Coordinator	M	204	$62,400	$81,120	$99,840	
	Graphic Designer	M	387	$62,400	$81,120	$99,840	
	Grievance & Appeals Nurse Specialist	N	226	$71,760	$93,184	$114,712	
	Grievance Resolution Specialist	J	42	$40,976	$53,352	$65,624	
	Grievance Resolution Specialist - Lead	L	590	$54,288	$70,512	$86,736	
	Grievance Resolution Specialist Sr	K	589	$47,112	$61,360	$75,504	
	Health Coach	M	556	$62,400	$81,120	$99,840	
	Health Educator	K	47	$47,112	$61,360	$75,504	
	Health Educator Sr	L	355	$54,288	$70,512	$86,736	
	Health Network Liaison Specialist (RN)	N	524	$71,760	$93,184	$114,712	
	Health Network Oversight Specialist	M	323	$62,400	$81,120	$99,840	
	HEDIS Case Manager	N	443	$71,760	$93,184	$114,712	
	HEDIS Case Manager (LVN)	M	552	$62,400	$81,120	$99,840	
	Help Desk Technician	J	571	$40,976	$53,352	$65,624	
	Help Desk Technician Sr	K	573	$47,112	$61,360	$75,504	
	HR Assistant	I	181	$37,128	$46,384	$55,640	
	HR Business Partner	M	584	$62,400	$81,120	$99,840	
	HR Compensation Specialist Sr	N	661	$71,760	$93,184	$114,712	
	HR Coordinator	J	316	$40,976	$53,352	$65,624	
	HR Representative	L	278	$54,288	$70,512	$86,736	
	HR Representative Sr	M	350	$62,400	$81,120	$99,840	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised October 4, 2018
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
HR Specialist	K	505	$47,112	$61,360	$75,504	
HR Specialist Sr	L	608	$54,288	$70,512	$86,736	
HRIS Analyst Sr	M	468	$62,400	$81,120	$99,840	
ICD-10 Project Manager	O	411	$82,576	$107,328	$131,976	
Infrastructure Systems Administrator	J	541	$40,976	$53,352	$65,624	
Infrastructure Systems Administrator Int	K	542	$47,112	$61,360	$75,504	
Inpatient Quality Coding Auditor	L	642	$54,288	$70,512	$86,736	
Intern	E	237	$25,272	$31,720	$37,960	
Investigator Sr	L	553	$54,288	$70,512	$86,736	
IS Coordinator	J	365	$40,976	$53,352	$65,624	
IS Project Manager	O	424	$82,576	$107,328	$131,976	
IS Project Manager Sr	P	509	$95,264	$128,752	$162,032	
IS Project Specialist	M	549	$62,400	$81,120	$99,840	
IS Project Specialist Sr	N	550	$71,760	$93,184	$114,712	
Kitchen Assistant	E	585	$25,272	$31,720	$37,960	
Legislative Program Manager	N	330	$71,760	$93,184	$114,712	
Licensed Clinical Social Worker	L	598	$54,288	$70,512	$86,736	
Litigation Support Specialist	M	588	$62,400	$81,120	$99,840	
LVN (PACE)	M	533	$62,400	$81,120	$99,840	
Mailroom Clerk	E	1	$25,272	$31,720	$37,960	
Manager Accounting	N	98	$71,760	$93,184	$114,712	
Manager Actuary	P	453	$95,264	$128,752	$162,032	
Manager Applications Management	P	271	$95,264	$128,752	$162,032	
Manager Audit & Oversight	O	539	$82,576	$107,328	$131,976	
Manager Behavioral Health	O	633	$82,576	$107,328	$131,976	
Manager Business Integration	O	544	$82,576	$107,328	$131,976	
Manager Case Management	O	270	$82,576	$107,328	$131,976	
Manager Claims	N	92	$71,760	$93,184	$114,712	
Manager Clinic Operations	O	551	$82,576	$107,328	$131,976	
Manager Clinical Pharmacist	Q	296	$114,400	$154,440	$194,480	
Manager Coding Quality	N	382	$71,760	$93,184	$114,712	
Manager Communications	N	398	$71,760	$93,184	$114,712	
Manager Community Relations	M	384	$62,400	$81,120	$99,840	
Manager Contracting	O	329	$82,576	$107,328	$131,976	
Manager Creative Branding	N	430	$71,760	$93,184	$114,712	
Manager Cultural & Linguistic	N	349	$71,760	$93,184	$114,712	
Manager Customer Service	N	94	$71,760	$93,184	$114,712	
Manager Decision Support	O	454	$82,576	$107,328	$131,976	
Manager Disease Management	O	372	$82,576	$107,328	$131,976	
Manager Electronic Business	O	422	$82,576	$107,328	$131,976	
Manager Employment Services	N	420	$71,760	$93,184	$114,712	
Manager Encounters	N	516	$71,760	$93,184	$114,712	
Manager Environmental Health & Safety	N	495	$71,760	$93,184	$114,712	
Manager Facilities	N	209	$71,760	$93,184	$114,712	
Manager Finance	N	148	$71,760	$93,184	$114,712	
Manager Financial Analysis	O	356	$82,576	$107,328	$131,976	
Manager Government Affairs	N	437	$71,760	$93,184	$114,712	
Manager Grievance & Appeals	N	426	$71,760	$93,184	$114,712	
Manager Health Education	N	173	$71,760	$93,184	$114,712	
Manager HEDIS	O	427	$82,576	$107,328	$131,976	
Manager Human Resources	O	526	$82,576	$107,328	$131,976	
Manager Information Services	P	560	$95,264	$128,752	$162,032	
Manager Information Technology	P	110	$95,264	$128,752	$162,032	
Manager Integration Government Liaison	N	455	$71,760	$93,184	$114,712	
Manager Long Term Support Services	O	200	$82,576	$107,328	$131,976	
Manager Marketing & Enrollment (PACE)	O	414	$82,576	$107,328	$131,976	
Manager Medical Data Management	O	519	$82,576	$107,328	$131,976	
Manager Medi-Cal Program Operations	N	483	$71,760	$93,184	$114,712	
Manager Member Liaison Program	N	354	$71,760	$93,184	$114,712	
Manager Member Outreach & Education	N	616	$71,760	$93,184	$114,712	
Manager Member Outreach Education & Provider Relations	O	576	$82,576	$107,328	$131,976	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised October 4, 2018
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Manager MSSP	O	393	$82,576	$107,328	$131,976	
	Manager OneCare Clinical	O	359	$82,576	$107,328	$131,976	
	Manager OneCare Customer Service	N	429	$71,760	$93,184	$114,712	
	Manager OneCare Regulatory	N	197	$71,760	$93,184	$114,712	
	Manager OneCare Sales	O	248	$82,576	$107,328	$131,976	
	Manager Outreach & Enrollment	N	477	$71,760	$93,184	$114,712	
	Manager PACE Center	O	432	$82,576	$107,328	$131,976	
	Manager Process Excellence	O	622	$82,576	$107,328	$131,976	
	Manager Program Implementation	O	488	$82,576	$107,328	$131,976	
	Manager Project Management	O	532	$82,576	$107,328	$131,976	
	Manager Provider Data Management Services	N	653	$71,760	$93,184	$114,712	
	Manager Provider Network	O	191	$82,576	$107,328	$131,976	
	Manager Provider Relations	N	171	$71,760	$93,184	$114,712	
	Manager Provider Services	O	656	$82,576	$107,328	$131,976	
	Manager Purchasing	N	275	$71,760	$93,184	$114,712	
	Manager QI Initiatives	N	433	$71,760	$93,184	$114,712	
	Manager Quality Analytics	O	617	$82,576	$107,328	$131,976	
	Manager Quality Improvement	O	104	$82,576	$107,328	$131,976	
	Manager Regulatory Affairs and Compliance	O	626	$82,576	$107,328	$131,976	
	Manager Reporting & Financial Compliance	O	572	$82,576	$107,328	$131,976	
	Manager Strategic Development	O	603	$82,576	$107,328	$131,976	
	Manager Strategic Operations	N	446	$71,760	$93,184	$114,712	
	Manager Systems Development	P	515	$95,264	$128,752	$162,032	
	Manager Utilization Management	O	250	$82,576	$107,328	$131,976	
	Marketing and Outreach Specialist	J	496	$40,976	$53,352	$65,624	
	Medical Assistant	H	535	$33,696	$42,224	$50,648	
	Medical Authorization Asst	H	11	$33,696	$42,224	$50,648	
	Medical Case Manager	N	72	$71,760	$93,184	$114,712	
	Medical Case Manager (LVN)	L	444	$54,288	$70,512	$86,736	
*	Medical Director	S	306	$164,736	$222,352	$280,072	
	Medical Records & Health Plan Assistant	G	548	$30,576	$38,272	$45,968	
	Medical Records Clerk	E	523	$25,272	$31,720	$37,960	
	Medical Services Case Manager	K	54	$47,112	$61,360	$75,504	
	Member Liaison Specialist	I	353	$37,128	$46,384	$55,640	
	MMS Program Coordinator	K	360	$47,112	$61,360	$75,504	
	Nurse Practitioner (PACE)	P	635	$95,264	$128,752	$162,032	
	Occupational Therapist	N	531	$71,760	$93,184	$114,712	
	Occupational Therapist Assistant	M	623	$62,400	$81,120	$99,840	
	Office Clerk	C	335	$21,008	$26,208	$31,408	
	OneCare Operations Manager	O	461	$82,576	$107,328	$131,976	
	OneCare Partner - Sales	K	230	$47,112	$61,360	$75,504	
	OneCare Partner - Sales (Lead)	K	537	$47,112	$61,360	$75,504	
	OneCare Partner - Service	I	231	$37,128	$46,384	$55,640	
	OneCare Partner (Inside Sales)	J	371	$40,976	$53,352	$65,624	
	Outreach Specialist	I	218	$37,128	$46,384	$55,640	
	Paralegal/Legal Secretary	K	376	$47,112	$61,360	$75,504	
	Payroll Specialist	J	554	$40,976	$53,352	$65,624	
	Performance Analyst	L	538	$54,288	$70,512	$86,736	
	Personal Care Attendant	E	485	$25,272	$31,720	$37,960	
	Personal Care Attendant - Lead	E	498	$25,272	$31,720	$37,960	
	Personal Care Coordinator	I	525	$37,128	$46,384	$55,640	
	Pharmacy Resident	K	379	$47,112	$61,360	$75,504	
	Pharmacy Services Specialist	I	23	$37,128	$46,384	$55,640	
	Pharmacy Services Specialist Int	J	35	$40,976	$53,352	$65,624	
	Pharmacy Services Specialist Sr	K	507	$47,112	$61,360	$75,504	
	Physical Therapist	N	530	$71,760	$93,184	$114,712	
	Physical Therapist Assistant	M	624	$62,400	$81,120	$99,840	
	Policy Advisor Sr	O	580	$82,576	$107,328	$131,976	
	Privacy Manager	N	536	$71,760	$93,184	$114,712	
	Privacy Officer	P	648	$95,264	$128,752	$162,032	
	Process Excellence Manager	O	529	$82,576	$107,328	$131,976	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised October 4, 2018
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Program Assistant	I	24	$37,128	$46,384	$55,640	
	Program Coordinator	I	284	$37,128	$46,384	$55,640	
	Program Development Analyst Sr	M	492	$62,400	$81,120	$99,840	
	Program Manager	M	421	$62,400	$81,120	$99,840	
	Program Manager Sr	O	594	$82,576	$107,328	$131,976	
	Program Specialist	J	36	$40,976	$53,352	$65,624	
	Program Specialist Int	K	61	$47,112	$61,360	$75,504	
	Program Specialist Sr	L	508	$54,288	$70,512	$86,736	
	Program/Policy Analyst	K	56	$47,112	$61,360	$75,504	
	Program/Policy Analyst Sr	M	85	$62,400	$81,120	$99,840	
	Programmer	L	43	$54,288	$70,512	$86,736	
	Programmer Int	N	74	$71,760	$93,184	$114,712	
	Programmer Sr	O	80	$82,576	$107,328	$131,976	
	Project Manager	M	81	$62,400	$81,120	$99,840	
	Project Manager - Lead	M	467	$62,400	$81,120	$99,840	
	Project Manager Sr	O	105	$82,576	$107,328	$131,976	
	Project Specialist	K	291	$47,112	$61,360	$75,504	
	Project Specialist Sr	L	503	$54,288	$70,512	$86,736	
	Projects Analyst	K	254	$47,112	$61,360	$75,504	
	Provider Enrollment Data Coordinator	I	12	$37,128	$46,384	$55,640	
	Provider Enrollment Data Coordinator Sr	J	586	$40,976	$53,352	$65,624	
	Provider Enrollment Manager	K	190	$47,112	$61,360	$75,504	
	Provider Network Rep Sr	L	391	$54,288	$70,512	$86,736	
	Provider Network Specialist	K	44	$47,112	$61,360	$75,504	
	Provider Network Specialist Sr	L	595	$54,288	$70,512	$86,736	
	Provider Office Education Manager	L	300	$54,288	$70,512	$86,736	
	Provider Relations Rep	K	205	$47,112	$61,360	$75,504	
	Provider Relations Rep Sr	L	285	$54,288	$70,512	$86,736	
	Publications Coordinator	J	293	$40,976	$53,352	$65,624	
	QA Analyst	L	486	$54,288	$70,512	$86,736	
	QA Analyst Sr	N	380	$71,760	$93,184	$114,712	
	QI Nurse Specialist	N	82	$71,760	$93,184	$114,712	
	QI Nurse Specialist (LVN)	M	445	$62,400	$81,120	$99,840	
	Receptionist	F	140	$27,872	$34,840	$41,808	
	Recreational Therapist	L	487	$54,288	$70,512	$86,736	
	Recruiter	L	406	$54,288	$70,512	$86,736	
	Recruiter Sr	M	497	$62,400	$81,120	$99,840	
	Registered Dietitian	L	57	$54,288	$70,512	$86,736	
	Regulatory Affairs and Compliance Analyst	K	628	$47,112	$61,360	$75,504	
	Regulatory Affairs and Compliance Analyst Sr	L	629	$54,288	$70,512	$86,736	
	Regulatory Affairs and Compliance Lead	M	630	$62,400	$81,120	$99,840	
	RN (PACE)	N	480	$71,760	$93,184	$114,712	
	Security Analyst Int	N	534	$71,760	$93,184	$114,712	
	Security Analyst Sr	O	474	$82,576	$107,328	$131,976	
	Security Officer	F	311	$27,872	$34,840	$41,808	
	SharePoint Developer/Administrator Sr	O	397	$82,576	$107,328	$131,976	
	Social Worker	K	463	$47,112	$61,360	$75,504	
*	Special Counsel	R	317	$137,280	$185,328	$233,376	
*	Sr Director Regulatory Affairs and Compliance	R	658	$137,280	$185,328	$233,376	
	Sr Manager Financial Analysis	P	660	$95,264	$128,752	$162,032	
	Sr Manager Human Resources	P	649	$95,264	$128,752	$162,032	
	Sr Manager Information Services	Q	650	$114,400	$154,440	$194,480	
	Sr Manager Government Affairs	O	451	$82,576	$107,328	$131,976	
	Sr Manager Provider Network	O	651	$82,576	$107,328	$131,976	
	Staff Attorney	P	195	$95,264	$128,752	$162,032	
	Supervisor Accounting	M	434	$62,400	$81,120	$99,840	
	Supervisor Audit and Oversight	N	618	$71,760	$93,184	$114,712	
	Supervisor Behavioral Health	N	659	$71,760	$93,184	$114,712	
	Supervisor Budgeting	M	466	$62,400	$81,120	$99,840	
	Supervisor Case Management	N	86	$71,760	$93,184	$114,712	
	Supervisor Claims	K	219	$47,112	$61,360	$75,504	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised October 4, 2018
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Supervisor Coding Initiatives	M	502	$62,400	$81,120	$99,840	
Supervisor Credentialing	L	TBD	$54,288	$70,512	$86,736	New Position
Supervisor Customer Service	K	34	$47,112	$61,360	$75,504	
Supervisor Data Entry	K	192	$47,112	$61,360	$75,504	
Supervisor Day Center (PACE)	K	619	$47,112	$61,360	$75,504	
Supervisor Dietary Services (PACE)	M	643	$62,400	$81,120	$99,840	
Supervisor Disease Management	N	644	$71,760	$93,184	$114,712	
Supervisor Encounters	L	253	$54,288	$70,512	$86,736	
Supervisor Facilities	L	162	$54,288	$70,512	$86,736	
Supervisor Finance	N	419	$71,760	$93,184	$114,712	
Supervisor Grievance and Appeals	M	620	$62,400	$81,120	$99,840	
Supervisor Health Education	M	381	$62,400	$81,120	$99,840	
Supervisor Information Services	N	457	$71,760	$93,184	$114,712	
Supervisor Long Term Support Services	N	587	$71,760	$93,184	$114,712	
Supervisor MSSP	N	348	$71,760	$93,184	$114,712	
Supervisor Nursing Services (PACE)	N	662	$71,760	$93,184	$114,712	
Supervisor OneCare Customer Service	K	408	$47,112	$61,360	$75,504	
Supervisor Payroll	M	517	$62,400	$81,120	$99,840	
Supervisor Pharmacist	P	610	$95,264	$128,752	$162,032	
Supervisor Provider Enrollment	K	439	$47,112	$61,360	$75,504	
Supervisor Provider Relations	M	652	$62,400	$81,120	$99,840	
Supervisor Quality Analytics	M	609	$62,400	$81,120	$99,840	
Supervisor Quality Improvement	N	600	$71,760	$93,184	$114,712	
Supervisor Regulatory Affairs and Compliance	N	627	$71,760	$93,184	$114,712	
Supervisor Social Work (PACE)	L	636	$54,288	$70,512	$86,736	
Supervisor Systems Development	O	456	$82,576	$107,328	$131,976	
Supervisor Therapy Services (PACE)	N	645	$71,760	$93,184	$114,712	
Supervisor Utilization Management	N	637	$71,760	$93,184	$114,712	
Systems Manager	N	512	$71,760	$93,184	$114,712	
Systems Network Administrator Int	M	63	$62,400	$81,120	$99,840	
Systems Network Administrator Sr	N	89	$71,760	$93,184	$114,712	
Systems Operations Analyst	J	32	$40,976	$53,352	$65,624	
Systems Operations Analyst Int	K	45	$47,112	$61,360	$75,504	
Technical Analyst Int	L	64	$54,288	$70,512	$86,736	
Technical Analyst Sr	M	75	$62,400	$81,120	$99,840	
Technical Writer	L	247	$54,288	$70,512	$86,736	
Technical Writer Sr	M	470	$62,400	$81,120	$99,840	
Therapy Aide	J	521	$40,976	$53,352	$65,624	
Training Administrator	L	621	$54,288	$70,512	$86,736	
Training Program Coordinator	K	471	$47,112	$61,360	$75,504	
Translation Specialist	G	241	$30,576	$38,272	$45,968	
Web Architect	O	366	$82,576	$107,328	$131,976	

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

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

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

Back to Agenda

Summary of Changes to Salary Schedule

For October 2018 Board Meeting:

Title	Old Wage Grade	New Job Code/ Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/ Changed
Supervisor Credentialing	N/A	L	The new position will be responsible for monitoring and leading the credentialing work activities to ensure that standards are met. This position will also review credential files for accuracy, assess credentialing staff workload, and act as a resource to the credentialing staff regarding CalOptima policies and procedures as well as regulatory and accreditation requirements.	N/A	October 2018

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action
Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion
At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

Back to Agenda

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

/s/ Michael Schrader — **Authorized Signature**

9/26/2018 — **Date**

Back to Agenda

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

Back to Agenda

Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

12. Consider Authorization of Expenditures in Support of CalOptima's Participation in Community Event

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Authorize the expenditure for CalOptima's participation in the following event:
    a. Up to $3,500 and staff participation at El Centro Cultural de Mexico's Noche de Altares on Saturday, November 3, 2018, in Downtown Santa Ana between 4th Street and Broadway;
2. Make a finding that such expenditure is for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the event and expenditure.

Background

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion

Staff recommends the authorization of expenditures for participation in this community event due in part to provide outreach and education about CalOptima's programs and services with members who identify themselves as Hispanic and Spanish-speaking members. Staff will have an opportunity to share information about eligible programs and services and increasing access to health care services for members in the Latino community.

El Centro Cultural de Mexico is an organization located in Santa Ana that fosters cultural, educational and artistic activities that preserve the Mexican culture in the community. They aim to strengthen the identity of the culture through community involvement and leadership. The Noche de Altares, or Night of Altars, is a community-based event where families, students, community organizations and businesses come together to create a cultural experience that reflects Mexican tradition. The event is

Back to Agenda

organized by volunteers and community leaders. This cultural event will provide an opportunity for CalOptima to serve the highest ethnicity represented in our membership. Staff will provide outreach and education about CalOptima's programs and services to our Hispanic members, who comprise approximately forty-six percent of CalOptima's membership. The event will be held in the city of Santa Ana, where nearly eighteen percent of our members reside. Attendees will learn about community resources while experiencing cultural activities, performances and music. The event is open and free to the public. This is the first year CalOptima has been invited to participate in this event.

Staff recommends CalOptima's continued support for this event at a $3,500 sponsorship level for 2018.

a. El Centro Cultural de Mexico's Noche de Altares event in Santa Ana includes a $3,500 financial commitment for the following: One (1) exhibitor booth, on-stage verbal recognition and promotion throughout event, CalOptima logo on event poster, event program, organizer's website and social media. Employee time will be used to participate in this event. Employees will have an opportunity to provide outreach and education with CalOptima's Hispanic members, representing forty-six percent of CalOptima's membership. Over twenty-five thousand (25,000) participants are anticipated to attend this event.

CalOptima staff has reviewed the request and it meets the consideration for participation including the following:

1. The number of people the activity/event will reach;
2. The marketing benefits accrued to CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity;
4. Past participation;
5. Staff availability;
6. Available budget.

CalOptima's involvement in community events is coordinated by the Community Relations department. The Community Relations department will take the lead to coordinate staff schedules, resources, and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

Funding for the recommended action of up to $3,500 is included as part of the Community Events budget under the CalOptima Fiscal Year 2018-19 Operating Budget approved by the CalOptima Board of Directors on June 7, 2018.

Rationale for Recommendation

Staff recommends approval of the recommended actions in order to support community and provider activities that offer opportunities that reflect CalOptima's mission, encourage broader participation in CalOptima's programs and services, or promote health and wellness.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachment
Event Information Package

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

Back to Agenda

Santa Ana's Noche de Altares

Since 2002, El Centro Cultural de Mexico has been organizing Noche de Altares, or a Night of Altars, a community based Dia de los Muertos celebration, where families, students, community organization and businesses come together to create an authentic cultural experience that reflects Mexican tradition and what makes up our communities today. Organized by volunteers, the purpose of the celebration is to honor the ancient traditions of the festival and bring community members together through art, culture, and compassion.

For one night, families, students, community organizations, activists, artists, and businesses are invited to build an altar in memory of a deceased loved one or to bring awareness to a social issue. By making altars, participants are inviting fellow community members into their own life and passions for a loved one. Over the years we have seen altars bring strangers together through mutual compassion, understanding and dialogue. Families reunite to remember and honor their loved ones.

In addition to viewing beautifully created altars, attendees will be entertained by cultural performances and live music. Children can get their face painted and participate in free, art workshops. Local artists will be selling their wares and local restaurants will be selling their most delicious dishes. Finally, attendees will have a photo opportunities with La Catrina, the modern-day icon of Dia de los Muertos created by Mexican artist Jose Guadalupe Posada.

Back to Agenda

Back to Agenda

AGENDA ITEM 13

Consider Chief Counsel Merit Compensation for the 2017-2018 Review Period

This item will be considered by the Board of Directors at the October 4, 2018 meeting.

Back to Agenda

Board of Directors Meeting
October 4, 2018

Member Advisory Committee (MAC) Update

September 13, 2018 MAC Meeting

Greg Hamblin, Chief Financial Officer, presented on CalOptima's Delivery System and Auto-Assignment Summary at the request of the Board of Directors. The Board of Directors is seeking recommendations from the MAC on CalOptima's delivery system strategy, as well as auto-assignment limits. MAC felt additional time is needed to discuss before recommendations can be made and agreed to hold a joint meeting with the Provider Advisory Committee (PAC) on October 11, 2018, at 8 am. MAC will then provide recommendations to the Board at the November 1, 2018 Board Meeting.

Candice Gomez, Executive Director, Program Implementation, presented on the Health Homes Program which will begin on July 1, 2019. Cheryl Meronk, Director, Strategic Planning, provided an update on Intergovernmental Transfer (IGT) Funds 5, 6 and 7. MAC received annual reports on Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and an overview on Cultural & Linguistics.

Michael Schrader, Chief Executive Officer, Ladan Khamseh, Chief Operating Officer, Emily Fonda M.D., Medical Director and Michelle Laughlin, Executive Director, Network Operations also provided management reports.

MAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the MAC's current activities.

Back to Agenda

Board of Directors Meeting
October 4, 2018

Provider Advisory Committee (PAC) Update

September 13, 2018 PAC Meeting

Twelve (12) PAC members were in attendance at the September PAC meeting.

PAC reviewed the directive from the Board and requested clarification on the directive from CalOptima staff. Greg Hamblin, Chief Financial Officer made two presentations on the CalOptima Delivery System Overview and the Member Auto-Assignment Limits for the CalOptima Community Network. Six public comments were received (five in person and one by letter) on these two topics. The PAC members had discussion and asked questions of staff to make sure they understood what was being asked of them by the CalOptima Board. A motion was made and seconded to hold a joint meeting on October 11, 2018 at 8 AM with the MAC, OCC MAC and PAC to allow more discussion and public comments from providers and community stakeholders. This would allow all the committees time to formulate a written response to the directive by the November 1, 2018 Board meeting.

Candice Gomez, Executive Director, Program Implementation presented on the Health Homes Program which will begin on July 1, 2019. PAC also received brief reports from Ladan Khamseh, Chief Operating Officer and Emily Fonda M.D., Medical Director.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's current activities.

Back to Agenda

Intergovernmental Transfer (IGT) Funding Update

Background:
The Rate Range Intergovernmental Transfer (IGT) program allows eligible government entities to voluntarily transfer public dollars to the Department of Health Care Services (DHCS) for the purpose of obtaining matching federal funding for Medi-Cal.

CalOptima completed seven IGT transactions, representing Rate Year 2010–11 through Rate Year 2016–17 (IGT 1 through IGT 7). At that time, IGT dollars received were based on a retrospective calculation of Medi-Cal costs for prior rate years. Consequently, the IGT dollars, once obtained, could only be used to fund enhanced services not already paid for or provided under CalOptima's contract with DHCS. The intent of the enhanced services funded by CalOptima's IGT efforts has been to enhance the health of the Medi-Cal members CalOptima serves.

Changes and Impact:
Effective July 2017, the Centers for Medicare & Medicaid Services (CMS) Medicaid Managed Care Final Rule, known as the Mega Reg includes medical loss ratio requirements that effectively prohibit retrospective payments to health plans (see 42 CFR 438 attached), starting with Rate Year 2017–18 (IGT 8). Therefore, the Rate Range IGT program had been restructured to a prospective payment model with IGT dollars included in the calculation of CalOptima's MLR in the year in which these dollars are received.

DHCS notified CalOptima regarding the availability of the 2017–18 Rate Range IGT program, and provided information about the above-referenced changes to the program and clarified that:

1) IGT payments to CalOptima from DHCS are included in the health plan's capitation rates for the current rate year, and
2) IGT payments are subject to all applicable requirements within CalOptima's contract with DHCS and must be tied to covered Medi-Cal services provided to beneficiaries in the current year.

In addition, DHCS hosted an informational call for Medi-Cal plans on November 16, 2017, to provide an overview of the changes to the Rate Range IGT program and to clarify the new program rules.

Based on the information provided by DHCS, CalOptima recognizes that the Mega Reg changes affect our expenditure of IGT funds for Rate Year 2017–18 (IGT 8) and Rate Year 2018–19 (IGT 9). Based on the rule change, IGT 8 and 9 funds are to be tied to Medi-Cal covered services provided in accordance with CalOptima's contract with DHCS and will be included in CalOptima's MLR calculations.

Attachment:
PowerPoint from DHCS informational call on 11/16/17

Back to Agenda

2017-18 Voluntary Rate Range Program

Presented by:

Capitated Rates Development Division

Back to Agenda

Agenda

- Voluntary Rate Range Program Overview
- SFY 2017-18 Request for MCP Proposal
- MCP Proposal
  - Soliciting Interest
  - Submission Requirements
  - Amendments to the MCP Proposal
  - State Review and Approval
- Questions?

Back to Agenda

Voluntary Rate Range Program Overview

Back to Agenda

Overview

- The Voluntary Rate Range Program provides a mechanism for funding the non-federal share of the managed care plan's (MCP's) actuarially sound rate range.
- Governmental funding entities may voluntarily transfer funds to the State via intergovernmental transfer (IGT).
  - Funding entities eligible to transfer the non-federal share:
    - Counties;
    - Cities;
    - Special purpose districts;
    - State university teaching hospitals; and
    - Other political subdivisions of the state, pursuant to Welfare & Institutions (W&I) Code, section 14163(a).

Back to Agenda

Intergovernmental Transfers

- Voluntary IGTs, together with the applicable federal financial participation (FFP), will be used to fund payments by the State to MCPs.

- Funds must qualify for FFP pursuant to Title 42, Code of Federal Regulations, Part 433, and shall not be derived from impermissible sources such as:
  - Recycled Medicaid payments;
  - Federal funds excluded from use as state match;
  - Impermissible taxes; and
  - Non-bona fide provider-related donations.

Back to Agenda

MCP Expenditure of Payments

- The State shall not direct the MCP's expenditure of payments received through the SFY 2017-18 Voluntary Rate Range Program.
  - Payments received by the MCP are subject to all applicable requirements in the MCP's contract with the State.
  - Payments must be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled in the MCP.

Back to Agenda

SFY 2017-18 Request for MCP Proposal

Back to Agenda

Request for MCP Proposals

- The State sent a Request For Proposal (RFP) to each MCP on November 8, 2017 (a correction was sent on November 15, 2017), that includes:
  - Attachment A – Letter of Interest format
  - Attachment B – SFY 2017-18 Voluntary Rate Range Program Supplemental Attachment
    - Funding entity questions and uncompensated costs/charges template
  - Attachment C – Draft rate range availability totals (total fund and contribution amounts)
    - Includes Classic and Optional Expansion populations
    - MCPs will receive final rate range availability totals in early December 2017.

Back to Agenda

Attachment A
Letter of Interest Format

- To participate, the MCP must obtain a Letter of Interest from each funding entity included in the MCP's proposal to the State. Each Letter of Interest must include:
  - Funding entity's name and Federal Tax Identification Number
  - Funding entity's intended contribution (dollar amount and percent of the total available rate range) for each county/region
  - Funding entity's primary contact information

Back to Agenda

Attachment B
Supplemental Attachment

- Attachment B collects required information about the funding entity and the provider (i.e., hospital or other health care organization) associated with the funding entity.

- A separate form must be completed for each MCP and county/region.
  - Funding entities must submit the completed forms to the State by December 14, 2017.

Back to Agenda

Attachment C
Rate Range Availability

- Attachment C provides the estimated SFY 2017-18 county/region-specific non-federal share required to fund available rate range amounts for the MCP.
  - The MCP's proposal and funding entity Letters of Interest must be based on the Governmental Funding Entity's Portion amounts indicated within the worksheet(s).
  - FFP percentages are included for calculation purposes only. The MCP's proposal may not differentiate amounts by FFP percentage.

- Note: MCPs will receive final worksheets in early December 2017.
  - Draft worksheets are provided to allow the MCP to begin negotiations with potential funding entities.

Back to Agenda

MCP Proposal

Back to Agenda

Soliciting Interest

- To participate, the MCP shall:
  - Contact potential funding entities to determine their interest, ability, and desired level of participation.
    - Proposed funding entities must meet the definition of Transferring Entity under W&I Code, section 14301.4.
  - Negotiate with potential funding entities regarding IGT contribution amounts and confirm each funding entity's ability to pay at the proposed levels.
  - Inform proposed funding entities that, unless a statutory exemption applies, IGTs are subject to a 20 percent assessment fee, which is calculated on the value of the IGT contribution.

Back to Agenda

Submission Requirements

- To participate, the MCP must submit a complete proposal to the State by December 14, 2017 that includes:
  - Dollars and percentages by funding entity
  - Dollars and percentage of the available rate range that would remain unfunded
  - A Letter of Interest completed by each proposed funding entity
  - All other submission requirements as outlined in the RFP

- Failure to submit all required documents by the due date may result in **the MCP's exclusion** from the SFY 2017-18 Voluntary Rate Range Program.
  - Unlike prior years, the State is not able to grant extensions.

Back to Agenda

Submission Requirements (cont.)

- Proposed funding entities must submit a completed Attachment B to the State for each MCP and county/region by December 14, 2017.
  - The State will not share cost/charge information with the MCP.

- Non-submission or late submission may result in **the funding entity's exclusion** from the SFY 2017-18 Voluntary Rate Range Program.
  - Unlike prior years, the State is not able to grant extensions.

Back to Agenda

Amendments to the MCP Proposal

- If, following the submission of the MCP's proposal, one or more proposed funding entities are unable or unwilling to fund the full amount of their portion of the non-federal share, the MCP shall attempt to find other funding entities able and willing to fund the differential.

Back to Agenda

State Review and Approval

- The State reserves the right to approve, amend or deny the MCP proposal at its discretion.
- If the MCP proposal is approved, the State will communicate:
  - Final, approved contribution amounts for each funding entity
  - Waivers of the 20% assessment fee, if applicable
  - Timelines for next steps
- The State will work directly with funding entities to execute funding agreements and collect IGT contributions.

Back to Agenda

Questions?

Back to Agenda

Financial Summary

August 2018

Board of Directors Meeting

October 4, 2018

Greg Hamblin

Chief Financial Officer

Back to Agenda

FY 2018-19: Consolidated Enrollment

- August 2018 MTD:
  - Overall enrollment was 775,841 member months
    - Actual lower than budget 8,968 or 1.1%
      - Medi-Cal: unfavorable variance of 7,268 members
        - Medi-Cal Expansion (MCE) unfavorable variance of 3,636
        - Temporary Assistance for Needy Families (TANF) unfavorable variance of 3,317 members
        - Senior Persons with Disabilities (SPD) unfavorable variance of 237 members
        - Long-Term Care (LTC) unfavorable variance of 78
      - OneCare Connect: unfavorable variance of 1,769 members
    - 2,693 decrease from prior month
      - Medi-Cal: increase of 562 from July
      - OneCare Connect: decrease of 3,262 from July
      - OneCare: decrease of 6 from July
      - PACE: increase of 13 from July

FY 2018-19: Consolidated Enrollment (cont.)

- August 2018 YTD:
  - Overall enrollment was 1,554,375 member months
    - Actual lower than budget 15,601 or 1.0%
      - Medi-Cal: unfavorable variance of 15,445 members or 1.0%
        - TANF unfavorable variance of 8,088 members
        - MCE unfavorable variance of 6,873 members
        - SPD unfavorable variance of 339 members
        - LTC unfavorable variance of 145 members
      - OneCare Connect: unfavorable variance of 293 members or 1.0%
      - OneCare: favorable variance of 126 or 4.8%
      - PACE: favorable variance of 11 members or 2.0%

FY 2018-19: Consolidated Revenues

- August 2018 MTD:
  - ➢ Actual higher than budget $7.4 million or 2.7%
    - ▪ Medi-Cal: favorable to budget $6.3 million or 2.6%
      - Unfavorable volume variance of $2.3 million
      - Favorable price variance of $8.6 million due to:
        - ➢ $4.7 million of prior year (PY) LTC revenue from non-LTC aid codes
        - ➢ $2.2 million of Proposition 56 revenue for July 2018
        - ➢ $1.2 million of Applied Behavior Analysis (ABA) revenue
        - ➢ $1.0 million of Coordinated Care Initiative (CCI) revenue
    - ▪ OneCare Connect: favorable to budget $2.0 million or 8.0%
      - Favorable price variance of $3.4 million due to Medicare Part D revenue adjustments

FY 2018-19: Consolidated Revenues (cont.)

- August 2018 MTD:
  - OneCare: unfavorable to budget $928.5 thousand or 57.3%
    - Favorable volume variance of $73.5 thousand
    - Unfavorable price variance of $1.0 million due to CMS revenue adjustment as a result of calendar year 2016 Hierarchical Condition Category (HCC) reconciliation
  - PACE: favorable to budget $43.3 thousand or 2.2%
    - Favorable volume variance of $65.2 thousand
    - Unfavorable price variance of $21.9 thousand

FY 2018-19: Consolidated Revenues (cont.)

- August 2018 YTD:
  - Actual higher than budget $2.3 million or 0.4%
    - Medi-Cal: unfavorable to budget $0.8 million or 0.2%
      - Unfavorable volume variance of $5.0 million
      - Favorable price variance of $4.2 million due to:
        - $4.6 million of PY LTC revenue from non-LTC aid codes
        - $1.1 million of FY18 CCI Revenue
        - $1.6 million of FY18 ABA revenue
        - $0.8 million of FY18 Hepatitis C revenue
        - ($3.0) million of FY18 non-LTC revenue from non-LTC aid codes
        - ($1.4) million of FY18 Proposition 56 revenue

FY 2018-19: Consolidated Revenues (cont.)

- August 2018 YTD:
  - OneCare Connect: favorable to budget $4.1 million or 8.2%
    - Unfavorable volume variance of $0.5 million
    - Favorable price variance of $4.6 million related to prior year Part D revenue adjustment
  - OneCare: Unfavorable to budget $1.1 million or 36.4%
    - Favorable volume variance of $0.2 million
    - Unfavorable price variance of $1.3 million due to CMS revenue adjustment as a result of calendar year 2016 HCC reconciliation
  - PACE: favorable to budget $0.2 million or 3.9%
    - Favorable volume variance of $0.1 million
    - Favorable price variance of $0.1 million

FY 2018-19: Consolidated Medical Expenses

- August 2018 MTD:
  - ➢ Actual higher than budget $7.7 million or 2.9%
    - Medi-Cal: unfavorable variance of $7.2 million
      - Favorable volume variance of $2.2 million
      - Unfavorable price variance of $9.4 million
        - ➢ Facilities unfavorable variance of $8.5 million due to claims Incurred But Not Reported (IBNR) restatement
        - ➢ Provider Capitation is unfavorable to budget $4.5 million due to Proposition 56 expense and Child Health and Disability Prevention (CHDP) that was budgeted in Professional Claims
        - ➢ Professional Claims favorable variance of $3.4 million due Behavioral Health Treatment (BHT) and CHDP expenses recorded in Provider Capitation
        - ➢ Medical Management favorable variance of $0.6 million due to open positions

Back to Agenda

FY 2018-19: Consolidated Medical Expenses (cont.)

- August 2018 MTD:
  - OneCare Connect: unfavorable variance of $0.7 million or 3.1%
    - Favorable volume variance of $2.9 million
    - Unfavorable price variance of $3.6 million
  - OneCare: favorable variance of $0.2 million
  - PACE: favorable variance of $47.1 thousand

Back to Agenda

FY 2018-19: Consolidated Medical Expenses (cont.)

- August 2018 YTD:
  - Actual higher than budget $1.9 million or 0.4%
    - Medi-Cal: unfavorable variance of $1.9 million
      - Favorable volume variance of $4.7 million
      - Unfavorable price variance of $6.6 million
        - Facilities expenses unfavorable variance of $7.9 million
        - Provider Capitation expenses unfavorable variance of $6.8 million
        - Professional Claim expenses favorable variance of $5.0 million
        - Prescription Drug expenses favorable variance of $1.5 million
    - OneCare Connect: unfavorable variance of $0.6 million
      - Favorable volume variance of $0.5 million
      - Unfavorable price variance of $1.0 million

- Medical Loss Ratio (MLR):
  - August 2018 MTD: Actual: 96.1% Budget: 95.9%
  - August 2018 YTD: Actual: 95.6% Budget: 95.6%

Back to Agenda

FY 2018-19: Consolidated Administrative Expenses

- August 2018 MTD:
  - Actual lower than budget $3.0 million or 22.7%
    - Salaries, wages and benefits: favorable variance of $1.8 million
    - Other categories: favorable variance of $1.2 million

- August 2018 YTD:
  - Actual lower than budget $5.1 million or 19.9%
    - Salaries, wages & benefits: favorable variance of $2.7 million
    - Purchased Services: favorable variance of $0.7 million
    - Other categories: favorable variance of $1.7 million

- Administrative Loss Ratio (ALR):
  - August 2018 MTD: Actual: 3.6% Budget: 4.7%
  - August 2018 YTD: Actual: 3.7% Budget: 4.7%

Back to Agenda

FY 2018-19: Change in Net Assets

- August 2018 MTD:
  - $4.5 million surplus
  - $5.7 million favorable to budget
    - Higher than budgeted revenue of $7.4 million
    - Higher than budgeted medical expenses of $7.7 million
    - Lower than budgeted administrative expenses of $3.0 million
    - Higher than budgeted investment and other income of $3.1 million

- August 2018 YTD:
  - $9.5 million surplus
  - $10.1 million favorable to budget
    - Higher than budgeted revenue of $2.3 million
    - Higher than budgeted medical expenses of $1.9 million
    - Lower than budgeted administrative expenses of $5.1 million
    - Higher than budgeted investment and other income of $4.6 million

Back to Agenda

Enrollment Summary: August 2018

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
63,762	63,995	(233)	(0.4%)	Aged	127,404	127,766	(362)	(0.3%)
612	620	(8)	(1.3%)	BCCTP	1,242	1,240	2	0.2%
47,117	47,113	4	0.0%	Disabled	94,238	94,217	21	0.0%
314,052	316,190	(2,138)	(0.7%)	TANF Child	627,283	632,899	(5,616)	(0.9%)
94,295	95,475	(1,180)	(1.2%)	TANF Adult	188,824	191,296	(2,472)	(1.3%)
3,382	3,460	(78)	(2.3%)	LTC	6,764	6,909	(145)	(2.1%)
237,814	241,450	(3,636)	(1.5%)	MCE	475,751	482,624	(6,873)	(1.4%)
761,034	**768,303**	**(7,268)**	**(0.9%)**	**Medi-Cal**	**1,521,506**	**1,536,951**	**(15,445)**	**(1.0%)**
13,137	**14,906**	**(1,769)**	**(11.9%)**	**OneCare Connect**	**29,536**	**29,829**	**(293)**	**(1.0%)**
286	**277**	**9**	**3.2%**	**PACE**	**559**	**548**	**11**	**2.0%**
1,384	**1,324**	**60**	**4.5%**	**OneCare**	**2,774**	**2,648**	**126**	**4.8%**
775,841	**784,810**	**(8,968)**	**(1.1%)**	**CalOptima Total**	**1,554,375**	**1,569,976**	**(15,601)**	**(1.0%)**

Back to Agenda

Financial Highlights: August 2018

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
775,841	784,810	(8,968)	-1.1%	Member Months	1,554,375	1,569,976	(15,601)	-1.0%
283,429,462	276,005,106	7,424,356	2.7%	Revenues	552,977,733	550,688,560	2,289,173	0.4%
272,362,360	264,617,724	(7,744,636)	-2.9%	Medical Expenses	528,390,911	526,454,955	(1,935,956)	-0.4%
10,088,153	13,046,642	2,958,489	22.7%	Administrative Expenses	20,519,760	25,628,381	5,108,621	19.9%
978,948	**(1,659,260)**	**2,638,208**	**159.0%**	**Operating Margin**	**4,067,063**	**(1,394,776)**	**5,461,838**	**391.6%**
3,505,317	416,667	3,088,651	741.3%	Non Operating Income (Loss)	5,433,317	833,333	4,599,983	552.0%
4,484,266	**(1,242,593)**	**5,726,859**	**460.9%**	**Change in Net Assets**	**9,500,379**	**(561,442)**	**10,061,822**	**1792.1%**
96.1%	95.9%	-0.2%		Medical Loss Ratio	95.6%	95.6%	0.0%	
3.6%	4.7%	1.2%		Administrative Loss Ratio	3.7%	4.7%	0.9%	
0.3%	-0.6%	0.9%		Operating Margin Ratio	0.7%	-0.3%	1.0%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

Consolidated Performance Actual vs. Budget: August 2018 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
1.2	(0.4)	1.7	Medi-Cal	2.6	0.9	1.7
0.5	(1.1)	1.6	OCC	1.9	(2.2)	4.1
(0.8)	(0.1)	(0.8)	OneCare	(1.0)	(0.2)	(0.8)
0.1	(0.0)	0.1	PACE	0.5	0.0	0.5
1.0	**(1.7)**	**2.6**	**Operating**	**4.0**	**(1.4)**	**5.4**
3.5	0.4	3.1	Inv./Rental Inc, MCO tax	5.5	0.8	4.6
3.5	**0.4**	**3.1**	**Non-Operating**	**5.5**	**0.8**	**4.6**
4.5	**(1.2)**	**5.7**	**TOTAL**	**9.5**	**(0.6)**	**10.1**

Back to Agenda

Consolidated Revenue & Expense: August 2018 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	523,220	237,814	761,034	13,137	1,384	286	775,841
REVENUES							
Capitation Revenue	$ 138,928,843	$ 114,770,717	$ 253,699,560	$ 26,987,349	$ 692,428	$ 2,050,126	$ 283,429,462
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	138,928,843	114,770,717	253,699,560	26,987,349	692,428	2,050,126	283,429,462
MEDICAL EXPENSES							
Provider Capitation	35,978,524	50,991,868	86,970,391	12,530,799	96,631		99,597,821
Facilities	26,070,355	25,897,754	51,968,109	3,042,337	734,542	476,582	56,221,570
Ancillary	-	-	-	608,841	45,091	-	653,932
Professional Claims	17,965,143	6,617,890	24,583,033	-	-	405,916	24,988,949
Prescription Drugs	18,086,178	20,754,799	38,840,976	5,564,495	345,685	138,423	44,889,580
MLTSS	33,689,699	2,942,845	36,632,544	1,584,958	123,840	2,576	38,343,917
Medical Management	2,215,253	881,419	3,096,672	1,127,611	39,260	628,133	4,891,676
Quality Incentives	770,905	404,824	1,175,729	280,180		2,860	1,458,769
Reinsurance & Other	697,220	237,117	934,337	200,000	6,500	175,311	1,316,147
Total Medical Expenses	135,473,275	108,728,515	244,201,790	24,939,221	1,391,549	1,829,800	272,362,360
Medical Loss Ratio	97.5%	94.7%	96.3%	92.4%	201.0%	89.3%	96.1%
GROSS MARGIN	**3,455,567**	**6,042,203**	**9,497,770**	**2,048,127**	**(699,122)**	**220,326**	**11,067,102**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			5,781,965	722,036	58,357	94,961	6,657,319
Professional fees			241,668	4,166	14,667	(2,576)	257,925
Purchased services			694,112	201,187	22,352	14,285	931,936
Printing & Postage			153,588	60,686	3,046	6,401	223,722
Depreciation & Amortization			392,048			2,074	394,122
Other expenses			1,190,141	50,573	-	(8,482)	1,232,231
Indirect cost allocation & Occupancy			(204,594)	557,394	34,965	3,134	390,898
Total Administrative Expenses			8,248,927	1,596,042	133,387	109,797	10,088,153
Admin Loss Ratio			3.3%	5.9%	19.3%	5.4%	3.6%
INCOME (LOSS) FROM OPERATIONS			1,248,842	452,085	(832,508)	110,529	978,948
INVESTMENT INCOME							3,514,802
TOTAL GRANT INCOME			(9,608)				(9,608)
OTHER INCOME			125				125
CHANGE IN NET ASSETS			**$ 1,239,358**	**$ 452,085**	**$ (832,508)**	**$ 110,529**	**$ 4,484,266**

Back to Agenda

Consolidated Revenue & Expense: August 2018 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,045,755	475,751	1,521,506	29,536	2,774	559	1,554,375
REVENUES							
Capitation Revenue	$ 270,179,591	$ 222,695,658	$ 492,875,249	$ 53,967,454	$ 2,007,906	$ 4,127,123	$ 552,977,733
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	270,179,591	222,695,658	492,875,249	53,967,454	2,007,906	4,127,123	552,977,733
MEDICAL EXPENSES							
Provider Capitation	71,611,968	100,058,029	171,669,997	24,412,114	450,167		196,532,278
Facilities	47,682,493	46,982,577	94,665,071	6,186,307	1,159,099	789,158	102,799,635
Ancillary	-	-	-	1,132,684	57,926	-	1,190,610
Professional Claims	34,854,197	14,695,306	49,549,503	-	-	800,207	50,349,710
Prescription Drugs	35,676,451	40,272,992	75,949,443	11,170,202	799,833	286,947	88,206,426
MLTSS	65,886,193	5,791,921	71,678,114	2,716,385	198,547	830	74,593,876
Medical Management	4,102,104	1,808,693	5,910,797	2,173,792	116,327	1,149,231	9,350,146
Quality Incentives	1,544,235	810,071	2,354,306	561,020		5,590	2,920,916
Reinsurance & Other	1,167,044	437,214	1,604,257	481,905	13,000	348,152	2,447,314
Total Medical Expenses	262,524,685	210,856,803	473,381,488	48,834,410	2,794,899	3,380,114	528,390,911
Medical Loss Ratio	97.2%	94.7%	96.0%	90.5%	139.2%	81.9%	95.6%
GROSS MARGIN	**7,654,906**	**11,838,855**	**19,493,761**	**5,133,045**	**(786,993)**	**747,009**	**24,586,822**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			11,896,970	1,548,206	58,357	185,723	13,689,257
Professional fees			351,134	8,334	29,334	224	389,026
Purchased services			1,375,770	372,402	29,545	17,100	1,794,818
Printing & Postage			515,680	100,406	6,738	6,401	629,225
Depreciation & Amortization			805,742			4,148	809,890
Other expenses			2,365,229	96,001	60	(2,935)	2,458,355
Indirect cost allocation & Occupancy			(441,763)	1,114,788	69,930	6,234	749,189
Total Administrative Expenses			16,868,763	3,240,137	193,964	216,895	20,519,760
Admin Loss Ratio			3.4%	6.0%	9.7%	5.3%	3.7%
INCOME (LOSS) FROM OPERATIONS			2,624,998	1,892,907	(980,957)	530,114	4,067,063
INVESTMENT INCOME							5,462,707
TOTAL GRANT INCOME			(29,674)				(29,674)
OTHER INCOME			285				285
CHANGE IN NET ASSETS			**$ 2,595,609**	**$ 1,892,907**	**$ (980,957)**	**$ 530,114**	**$ 9,500,379**

Back to Agenda

CalOptima A Public Agency Better. Together.

Balance Sheet:
As of August 2018

ASSETS		LIABILITIES & FUND BALANCES	
Current Assets		Current Liabilities	
Operating Cash	$515,126,697	Accounts Payable	$27,340,664
Investments	384,790,436	Medical Claims liability	798,445,025
Capitation receivable	349,281,991	Accrued Payroll Liabilities	12,122,006
Receivables - Other	23,314,880	Deferred Revenue	109,018,787
Prepaid expenses	6,469,472	Deferred Lease Obligations	108,100
		Capitation and Withholds	109,884,755
Total Current Assets	**1,278,983,476**	**Total Current Liabilities**	**1,056,919,336**
Capital Assets			
Furniture & Equipment	34,328,849		
Building/Leasehold Improvements	8,216,084		
505 City Parkway West	49,743,943		
	92,288,876		
Less: accumulated depreciation	(42,121,609)		
Capital assets, net	50,167,267	Other (than pensions) post employment benefits liability	24,818,101
Other Assets		Net Pension Liabilities	24,979,118
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	100,000
Board-designated assets			
Cash and Cash Equivalents	11,807,176	**TOTAL LIABILITIES**	**1,106,816,554**
Long-term Investments	528,886,911		
Total Board-designated Assets	540,694,087	Deferred Inflows	
Total Other Assets	540,994,087	Change in Assumptions	3,329,380
TOTAL ASSETS	**1,870,144,830**	TNE	84,945,052
		Funds in Excess of TNE	686,186,894
Deferred Outflows			
Pension Contributions	953,907		
Difference in Experience	1,365,903	Net Assets	771,131,946
Excess Earnings	1,017,387		
Changes in Assumptions	7,795,853		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,881,277,880**	**TOTAL LIABILITIES & FUND BALANCES**	**1,881,277,880**

Back to Agenda

CalOptima A Public Agency Better. Together.

Board Designated Reserve and TNE Analysis
As of August 2018

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	147,914,240				
	Tier 1 - Logan Circle	147,864,857				
	Tier 1 - Wells Capital	147,242,444				
Board-designated Reserve		443,021,541	317,442,949	489,894,949	125,578,593	(46,873,408)
TNE Requirement	Tier 2 - Logan Circle	97,672,546	84,945,052	84,945,052	12,727,494	12,727,494
	Consolidated:	**540,694,087**	**402,388,001**	**574,840,001**	**138,306,087**	**(34,145,914)**
	Current reserve level	*1.88*	*1.40*	*2.00*		

Back to Agenda

UNAUDITED FINANCIAL STATEMENTS

August 2018

Back to Agenda

Table of Contents

Back to Agenda

CalOptima - Consolidated
Financial Highlights
For the Two Months Ended August 31, 2018

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
775,841	784,810	(8,968)	-1.1%	Member Months	1,554,375	1,569,976	(15,601)	-1.0%
283,429,462	276,005,106	7,424,356	2.7%	Revenues	552,977,733	550,688,560	2,289,173	0.4%
272,362,360	264,617,724	(7,744,636)	-2.9%	Medical Expenses	528,390,911	526,454,955	(1,935,956)	-0.4%
10,088,153	13,046,642	2,958,489	22.7%	Administrative Expenses	20,519,760	25,628,381	5,108,621	19.9%
978,948	**(1,659,260)**	**2,638,208**	**159.0%**	**Operating Margin**	**4,067,063**	**(1,394,776)**	**5,461,838**	**391.6%**
3,505,317	416,667	3,088,651	741.3%	Non Operating Income (Loss)	5,433,317	833,333	4,599,983	552.0%
4,484,266	**(1,242,593)**	**5,726,859**	**460.9%**	**Change in Net Assets**	**9,500,379**	**(561,442)**	**10,061,822**	**1792.1%**
96.1%	95.9%	-0.2%		Medical Loss Ratio	95.6%	95.6%	0.0%	
3.6%	4.7%	1.2%		Administrative Loss Ratio	3.7%	4.7%	0.9%	
0.3%	-0.6%	0.9%		Operating Margin Ratio	0.7%	-0.3%	1.0%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

CalOptima
Financial Dashboard
For the Two Months Ended August 31, 2018

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	761,034	768,303	(7,269)	(0 9%)
OneCare Connect	13,137	14,905	(1,768)	(11 9%)
OneCare	1,384	1,324	60	4 5%
PACE	286	277	9	3 2%
Total	775,841	784,810	(8,968)	(1 1%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 1,239	$ (420)	$ 1,659	395 0%
OneCare Connect	452	(1,148)	1,600	139 4%
OneCare	(833)	(57)	(776)	(1361 4%)
PACE	111	(34)	145	426 5%
505 Bldg	-	-	-	0 0%
Investment Income & Other	3,515	417	3,098	742 9%
Total	$ 4,484	$ (1,242)	$ 5,726	461 0%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96 3%	95 8%	(0 5)
OneCare Connect	92 4%	96 9%	4 4
OneCare	201 0%	95 3%	(105 7)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 8,249	$ 10,814	$ 2,565	23 7%
OneCare Connect	1,596	1,935	339	17 5%
OneCare	133	134	1	0 4%
PACE	110	164	55	33 2%
Total	$ 10,088	$ 13,047	$ 2,958	22 7%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	924	1,037	113
OneCare Connect	219	234	15
OneCare	6	6	0
PACE	60	78	17
Total	1,209	1,355	146

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	824	741	83
OneCare Connect	60	64	(4)
OneCare	245	221	25
PACE	5	4	1
Total	1,133	1,028	105

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	1,521,506	1,536,951	(15,445)	(1 0%)
OneCare Connect	29,536	29,828	(292)	(1 0%)
OneCare	2,774	2,648	126	4 8%
PACE	559	548	11	2 0%
Total	1,554,375	1,569,976	(15,601)	(1 0%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 2,596	$ 944	$ 1,652	175 0%
OneCare Connect	1,893	(2,212)	4,105	185 6%
OneCare	(981)	(158)	(823)	(520 9%)
PACE	530	32	498	1556 3%
505 Bldg	-	-	-	0 0%
Investment Income & Other	5,463	833	4,630	555 8%
Total	$ 9,501	$ (561)	$ 10,062	1793 6%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96 0%	95 5%	(0 5)
OneCare Connect	90 5%	96 8%	6 3
OneCare	139 2%	96 6%	(42 6)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 16,869	$ 21,226	$ 4,357	20 5%
OneCare Connect	3,240	3,831	591	15 4%
OneCare	194	266	72	27 1%
PACE	217	306	89	29 1%
Total	$ 20,520	$ 25,628	$ 5,109	19 9%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,855	2,064	209
OneCare Connect	439	468	29
OneCare	9	12	3
PACE	119	144	25
Total	4,616	2,688	(1,928)

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	820	745	75
OneCare Connect	67	64	4
OneCare	322	221	101
PACE	5	4	1
Total	1,214	1,033	181

Back to Agenda

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended August 31, 2018

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	775,841		784,810		(8,968)	
REVENUE						
Medi-Cal	$ 253,699,560	$ 333 36	$ 247,390,925	$ 322 00	$ 6,308,635	$ 11 36
OneCare Connect	26,987,349	2,054 30	24,986,423	1,676 38	2,000,926	377 92
OneCare	692,428	500 31	1,620,960	1,224 29	(928,532)	(723 98)
PACE	2,050,126	7,168 27	2,006,799	7,244 76	43,327	(76 49)
Total Operating Revenue	283,429,462	365 32	276,005,106	351 68	7,424,356	13 64
MEDICAL EXPENSES						
Medi-Cal	244,201,790	320 88	236,996,787	308 47	(7,205,003)	(12 41)
OneCare Connect	24,939,221	1,898 40	24,200,046	1,623 62	(739,175)	(274 78)
OneCare	1,391,549	1,005 45	1,544,033	1,166 19	152,484	160 74
PACE	1,829,800	6,397 90	1,876,858	6,775 66	47,058	377 76
Total Medical Expenses	272,362,360	351 05	264,617,724	337 17	(7,744,636)	(13 88)
GROSS MARGIN	11,067,102	14 27	11,387,382	14 51	(320,280)	(0 24)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	6,657,319	8 58	8,447,758	10 76	1,790,439	2 18
Professional fees	257,925	0 33	412,333	0 53	154,408	0 20
Purchased services	931,936	1 20	1,235,014	1 57	303,078	0 37
Printing & Postage	223,722	0 29	533,146	0 68	309,423	0 39
Depreciation & Amortization	394,122	0 51	464,166	0 59	70,044	0 08
Other expenses	1,232,231	1 59	1,581,992	2 02	349,761	0 43
Indirect cost allocation & Occupancy expense	390,898	0 50	372,234	0 47	(18,665)	(0 03)
Total Administrative Expenses	10,088,153	13 00	13,046,642	16 62	2,958,489	3 62
INCOME (LOSS) FROM OPERATIONS	978,948	1 26	(1,659,260)	(2 11)	2,638,208	3 37
INVESTMENT INCOME						
Interest income	2,392,819	3 08	416,667	0 53	1,976,152	2 55
Realized gain/(loss) on investments	(200,068)	(0 26)	-	-	(200,068)	(0 26)
Unrealized gain/(loss) on investments	1,322,050	1 70	-	-	1,322,050	1 70
Total Investment Income	3,514,802	4 53	416,667	0 53	3,098,135	4 00
TOTAL GRANT INCOME	(9,608)	(0 01)	-	-	(9,608)	(0 01)
OTHER INCOME	125	-	-	-	125	-
CHANGE IN NET ASSETS	**4,484,266**	**5.78**	**(1,242,593)**	**(1.58)**	**5,726,859**	**7.36**
MEDICAL LOSS RATIO	**96.1%**		**95.9%**		**-0.2%**	
ADMINISTRATIVE LOSS RATIO	**3.6%**		**4.7%**		**1.2%**	

Back to Agenda

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2018

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	1,554,375		1,569,976		(15,601)	
REVENUE						
Medi-Cal	$ 492,875,249	$ 323.94	$ 493,678,602	$ 321.21	$ (803,353)	$ 2.73
OneCare Connect	53,967,454	1,827.18	49,881,517	1,672.31	4,085,937	154.87
OneCare	2,007,906	723.83	3,157,396	1,192.37	(1,149,490)	(468.54)
PACE	4,127,123	7,383.05	3,971,045	7,246.43	156,078	136.62
Total Operating Revenue	552,977,733	355.76	550,688,560	350.76	2,289,173	5.00
MEDICAL EXPENSES						
Medi-Cal	473,381,488	311.13	471,509,328	306.78	(1,872,160)	(4.35)
OneCare Connect	48,834,410	1,653.39	48,263,027	1,618.04	(571,383)	(35.35)
OneCare	2,794,899	1,007.53	3,049,641	1,151.68	254,742	144.15
PACE	3,380,114	6,046.72	3,632,958	6,629.49	252,844	582.77
Total Medical Expenses	528,390,911	339.94	526,454,955	335.33	(1,935,956)	(4.61)
GROSS MARGIN	24,586,822	15.82	24,233,605	15.43	353,217	0.39
ADMINISTRATIVE EXPENSES						
Salaries and benefits	13,689,257	8.81	16,430,613	10.47	2,741,356	1.66
Professional fees	389,026	0.25	824,666	0.53	435,640	0.28
Purchased services	1,794,818	1.15	2,472,523	1.57	677,705	0.42
Printing & Postage	629,225	0.40	1,066,291	0.68	437,066	0.28
Depreciation & Amortization	809,890	0.52	928,332	0.59	118,442	0.07
Other expenses	2,458,355	1.58	3,161,489	2.01	703,134	0.43
Indirect cost allocation & Occupancy expense	749,189	0.48	744,466	0.47	(4,723)	(0.01)
Total Administrative Expenses	20,519,760	13.20	25,628,381	16.32	5,108,621	3.12
INCOME (LOSS) FROM OPERATIONS	4,067,063	2.62	(1,394,776)	(0.89)	5,461,838	3.51
INVESTMENT INCOME						
Interest income	4,790,256	3.08	833,333	0.53	3,956,923	2.55
Realized gain/(loss) on investments	(428,801)	(0.28)	-	-	(428,801)	(0.28)
Unrealized gain/(loss) on investments	1,101,251	0.71	-	-	1,101,251	0.71
Total Investment Income	5,462,707	3.51	833,333	0.53	4,629,373	2.98
TOTAL GRANT INCOME	(29,674)	(0.02)	-	-	(29,674)	(0.02)
OTHER INCOME	285	-	-	-	285	-
CHANGE IN NET ASSETS	**9,500,379**	**6.11**	**(561,442)**	**(0.36)**	**10,061,822**	**6.47**
MEDICAL LOSS RATIO	**95.6%**		**95.6%**		**0.0%**	
ADMINISTRATIVE LOSS RATIO	**3.7%**		**4.7%**		**0.9%**	

Back to Agenda

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended August 31, 2018

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	523,220	237,814	761,034	13,137	1,384	286	775,841
REVENUES							
Capitation Revenue	$ 138,928,843	$ 114,770,717	$ 253,699,560	$ 26,987,349	$ 692,428	$ 2,050,126	$ 283,429,462
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	138,928,843	114,770,717	253,699,560	26,987,349	692,428	2,050,126	283,429,462
MEDICAL EXPENSES							
Provider Capitation	35,978,524	50,991,868	86,970,391	12,530,799	96,631		99,597,821
Facilities	26,070,355	25,897,754	51,968,109	3,042,337	734,542	476,582	56,221,570
Ancillary	-	-	-	608,841	45,091	-	653,932
Professional Claims	17,965,143	6,617,890	24,583,033	-	-	405,916	24,988,949
Prescription Drugs	18,086,178	20,754,799	38,840,976	5,564,495	345,685	138,423	44,889,580
MLTSS	33,689,699	2,942,845	36,632,544	1,584,958	123,840	2,576	38,343,917
Medical Management	2,215,253	881,419	3,096,672	1,127,611	39,260	628,133	4,891,676
Quality Incentives	770,905	404,824	1,175,729	280,180		2,860	1,458,769
Reinsurance & Other	697,220	237,117	934,337	200,000	6,500	175,311	1,316,147
Total Medical Expenses	135,473,275	108,728,515	244,201,790	24,939,221	1,391,549	1,829,800	272,362,360
Medical Loss Ratio	97 5%	94 7%	96 3%	92 4%	201 0%	89 3%	96 1%
GROSS MARGIN	**3,455,567**	**6,042,203**	**9,497,770**	**2,048,127**	**(699,122)**	**220,326**	**11,067,102**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			5,781,965	722,036	58,357	94,961	6,657,319
Professional fees			241,668	4,166	14,667	(2,576)	257,925
Purchased services			694,112	201,187	22,352	14,285	931,936
Printing & Postage			153,588	60,686	3,046	6,401	223,722
Depreciation & Amortization			392,048			2,074	394,122
Other expenses			1,190,141	50,573	-	(8,482)	1,232,231
Indirect cost allocation & Occupancy			(204,594)	557,394	34,965	3,134	390,898
Total Administrative Expenses			8,248,927	1,596,042	133,387	109,797	10,088,153
Admin Loss Ratio			3 3%	5 9%	19 3%	5 4%	3 6%
INCOME (LOSS) FROM OPERATIONS			1,248,842	452,085	(832,508)	110,529	978,948
INVESTMENT INCOME							3,514,802
TOTAL GRANT INCOME			(9,608)				(9,608)
OTHER INCOME			125				125
CHANGE IN NET ASSETS			**$ 1,239,358**	**$ 452,085**	**$ (832,508)**	**$ 110,529**	**$ 4,484,266**
BUDGETED CHANGE IN NET ASSETS			(419,730)	(1,148,172)	(56,961)	(34,397)	(1,242,593)
VARIANCE TO BUDGET - FAV (UNFAV)			$ 1,659,089	$ 1,600,257	$ (775,548)	$ 144,927	$ 5,726,859

Back to Agenda

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Two Months Ended August 31, 2018

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,045,755	475,751	1,521,506	29,536	2,774	559	1,554,375
REVENUES							
Capitation Revenue	$ 270,179,591	$ 222,695,658	$ 492,875,249	$ 53,967,454	$ 2,007,906	$ 4,127,123	$ 552,977,733
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	270,179,591	222,695,658	492,875,249	53,967,454	2,007,906	4,127,123	552,977,733
MEDICAL EXPENSES							
Provider Capitation	71,611,968	100,058,029	171,669,997	24,412,114	450,167		196,532,278
Facilities	47,682,493	46,982,577	94,665,071	6,186,307	1,159,099	789,158	102,799,635
Ancillary	-	-	-	1,132,684	57,926	-	1,190,610
Professional Claims	34,854,197	14,695,306	49,549,503	-	-	800,207	50,349,710
Prescription Drugs	35,676,451	40,272,992	75,949,443	11,170,202	799,833	286,947	88,206,426
MLTSS	65,886,193	5,791,921	71,678,114	2,716,385	198,547	830	74,593,876
Medical Management	4,102,104	1,808,693	5,910,797	2,173,792	116,327	1,149,231	9,350,146
Quality Incentives	1,544,235	810,071	2,354,306	561,020		5,590	2,920,916
Reinsurance & Other	1,167,044	437,214	1,604,257	481,905	13,000	348,152	2,447,314
Total Medical Expenses	262,524,685	210,856,803	473,381,488	48,834,410	2,794,899	3,380,114	528,390,911
Medical Loss Ratio	97 2%	94 7%	96 0%	90 5%	139 2%	81 9%	95 6%
GROSS MARGIN	**7,654,906**	**11,838,855**	**19,493,761**	**5,133,045**	**(786,993)**	**747,009**	**24,586,822**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			11,896,970	1,548,206	58,357	185,723	13,689,257
Professional fees			351,134	8,334	29,334	224	389,026
Purchased services			1,375,770	372,402	29,545	17,100	1,794,818
Printing & Postage			515,680	100,406	6,738	6,401	629,225
Depreciation & Amortization			805,742			4,148	809,890
Other expenses			2,365,229	96,001	60	(2,935)	2,458,355
Indirect cost allocation & Occupancy			(441,763)	1,114,788	69,930	6,234	749,189
Total Administrative Expenses			16,868,763	3,240,137	193,964	216,895	20,519,760
Admin Loss Ratio			3 4%	6 0%	9 7%	5 3%	3 7%
INCOME (LOSS) FROM OPERATIONS			2,624,998	1,892,907	(980,957)	530,114	4,067,063
INVESTMENT INCOME							5,462,707
TOTAL GRANT INCOME			(29,674)				(29,674)
OTHER INCOME			285				285
CHANGE IN NET ASSETS			**$ 2,595,609**	**$ 1,892,907**	**$ (980,957)**	**$ 530,114**	**$ 9,500,379**
BUDGETED CHANGE IN NET ASSETS			943,653	(2,212,390)	(158,380)	32,341	(561,442)
VARIANCE TO BUDGET - FAV (UNFAV)			$ 1,651,955	$ 4,105,298	$ (822,577)	$ 497,772	$ 10,061,822

Back to Agenda

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $4.5 million, $5.7 million favorable to budget
- Operating surplus is $1.0 million with a surplus in non-operating of $3.5 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $9.5 million, $10.1 million favorable to budget
- Operating surplus is $4.0 million, with a surplus in non-operating of $5.5 million

Change in Net Assets by LOB ($millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
1.2	(0.4)	1.7	Medi-Cal	2.6	0.9	1.7
0.5	(1.1)	1.6	OCC	1.9	(2.2)	4.1
(0.8)	(0.1)	(0.8)	OneCare	(1.0)	(0.2)	(0.8)
0.1	(0.0)	0.1	PACE	0.5	0.0	0.5
1.0	**(1.7)**	**2.6**	**Operating**	**4.0**	**(1.4)**	**5.4**
3.5	0.4	3.1	Inv./Rental Inc, MCO tax	5.5	0.8	4.6
3.5	**0.4**	**3.1**	**Non-Operating**	**5.5**	**0.8**	**4.6**
4.5	**(1.2)**	**5.7**	**TOTAL**	**9.5**	**(0.6)**	**10.1**

Back to Agenda

CalOptima
Enrollment Summary
For the Two Months Ended August 31, 2018

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
63,762	63,995	(233)	(0.4%)	Aged	127,404	127,766	(362)	(0.3%)
612	620	(8)	(1.3%)	BCCTP	1,242	1,240	2	0.2%
47,117	47,113	4	0.0%	Disabled	94,238	94,217	21	0.0%
314,052	316,190	(2,138)	(0.7%)	TANF Child	627,283	632,899	(5,616)	(0.9%)
94,295	95,475	(1,180)	(1.2%)	TANF Adult	188,824	191,296	(2,472)	(1.3%)
3,382	3,460	(78)	(2.3%)	LTC	6,764	6,909	(145)	(2.1%)
237,814	241,450	(3,636)	(1.5%)	MCE	475,751	482,624	(6,873)	(1.4%)
761,034	**768,303**	**(7,268)**	**(0.9%)**	**Medi-Cal**	**1,521,506**	**1,536,951**	**(15,445)**	**(1.0%)**
13,137	**14,906**	**(1,769)**	**(11.9%)**	**OneCare Connect**	**29,536**	**29,829**	**(293)**	**(1.0%)**
286	**277**	**9**	**3.2%**	**PACE**	**559**	**548**	**11**	**2.0%**
1,384	**1,324**	**60**	**4.5%**	**OneCare**	**2,774**	**2,648**	**126**	**4.8%**
775,841	**784,810**	**(8,968)**	**(1.1%)**	**CalOptima Total**	**1,554,375**	**1,569,976**	**(15,601)**	**(1.0%)**
				Enrollment (By Network)				
166,900	168,338	(1,438)	(0.9%)	HMO	333,996	336,858	(2,862)	(0.8%)
217,292	222,302	(5,010)	(2.3%)	PHC	435,083	444,668	(9,585)	(2.2%)
192,395	193,343	(948)	(0.5%)	Shared Risk Group	385,577	387,493	(1,916)	(0.5%)
184,447	184,320	127	0.1%	Fee for Service	366,850	367,932	(1,082)	(0.3%)
761,034	**768,303**	**(7,268)**	**(0.9%)**	**Medi-Cal**	**1,521,506**	**1,536,951**	**(15,445)**	**(1.0%)**
13,137	**14,906**	**(1,769)**	**(11.9%)**	**OneCare Connect**	**29,536**	**29,829**	**(293)**	**(1.0%)**
286	**277**	**9**	**3.2%**	**PACE**	**559**	**548**	**11**	**2.0%**
1,384	**1,324**	**60**	**4.5%**	**OneCare**	**2,774**	**2,648**	**126**	**4.8%**
775,841	**784,810**	**(8,968)**	**(1.1%)**	**CalOptima Total**	**1,554,375**	**1,569,976**	**(15,601)**	**(1.0%)**

Back to Agenda

CalOptima
Enrollment Trend by Network Type
Fiscal Year 2019

Network Type	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	MMs
HMO													
Aged	3,844	3,866											7,710
BCCTP	1	1											2
Disabled	6,744	6,789											13,533
TANF Child	58,435	58,267											116,702
TANF Adult	29,473	29,373											58,846
LTC	2	2											4
MCE	68,597	68,602											137,199
	167,096	166,900											333,996
PHC													
Aged	1,600	1,621											3,221
BCCTP	-	-											-
Disabled	7,243	7,239											14,482
TANF Child	157,157	156,755											313,912
TANF Adult	12,731	12,684											25,415
LTC	-	1											1
MCE	39,060	38,992											78,052
	217,791	217,292											435,083
Shared Risk Group													
Aged	3,593	3,605											7,198
BCCTP	-	-											-
Disabled	7,626	7,554											15,180
TANF Child	67,471	67,226											134,697
TANF Adult	30,936	30,567											61,503
LTC	2	-											2
MCE	83 554	83 443											166 997
	193 182	192 395											385 577
Fee for Service (Dual)													
Aged	49,903	50,943											100,846
BCCTP	16	15											31
Disabled	20,706	20,863											41,569
TANF Child	2	3											5
TANF Adult	1,081	1,083											2,164
LTC	3,025	3,019											6,044
MCE	2,327	2,367											4,694
	77,060	78,293											155,353
Fee for Service (Non-Dual)													
Aged	4,702	3,727											8,429
BCCTP	613	596											1,209
Disabled	4,802	4,672											9,474
TANF Child	30,166	31,801											61,967
TANF Adult	20,308	20,588											40,896
LTC	353	360											713
MCE	44,399	44,410											88,809
	105,343	106,154											211,497
MEDI-CAL TOTAL													
Aged	63,642	63,762											127,404
BCCTP	630	612											1,242
Disabled	47,121	47,117											94,238
TANF Child	313,231	314,052											627,283
TANF Adult	94,529	94,295											188,824
LTC	3,382	3,382											6,764
MCE	237 937	237 814											475 751
	760,472	761,034											1,521,506
PACE	273	286											559
OneCare	1,390	1,384											2,774
OneCare Connect	16,399	13,137											29,536
TOTAL	778,534	775,841											1,554,375

Back to Agenda

ENROLLMENT:

Overall MTD enrollment was 775,841

- Unfavorable to budget 8,968 or 1.1%
- Decreased 2,693 or 0.3% from prior month (July 2018)
- Decreased 22,150 or 2.8% from prior year (August 2017)

Medi-Cal enrollment was 761,034

- Unfavorable to budget 7,268
    - Temporary Assistance for Needy Families (TANF) unfavorable 3,317
    - Senior Persons with Disabilities (SPD) unfavorable 237
    - Medi-Cal Expansion (MCE) unfavorable 3,636
    - Long-Term Care (LTC) unfavorable 78
- Increased 562 from prior month

OneCare Connect enrollment was 13,137

- Unfavorable to budget 1,769
- Decreased 3,262 from prior month due to adjustment of prior years' members with no health networks

OneCare enrollment was 1,384

- Favorable to budget 60
- Decreased 6 from prior month

PACE enrollment was 286

- Favorable to budget 9
- Increased 13 from prior month

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2018

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
761,034	**768,303**	**(7,268)**	**(0.9%)**	**Member Months**	**1,521,506**	**1,536,951**	**(15,445)**	**(1.0%)**
				Revenues				
253,699,560	247,390,925	6,308,635	2 6%	Capitation revenue	492,875,249	493,678,602	(803,353)	(0 2%)
-	-	-	0 0%	Other income	-	-	-	0 0%
253,699,560	**247,390,925**	**6,308,635**	**2.6%**	**Total Operating Revenue**	**492,875,249**	**493,678,602**	**(803,353)**	**(0.2%)**
				Medical Expenses				
88,146,120	84,446,316	(3,699,804)	(4 4%)	Provider capitation	174,024,303	168,915,160	(5,109,143)	(3 0%)
51,968,109	43,876,933	(8,091,176)	(18 4%)	Facilities	94,665,071	87,666,662	(6,998,409)	(8 0%)
24,583,033	28,280,046	3,697,013	13 1%	Professional claims	49,549,503	55,148,441	5,598,939	10 2%
38,840,976	39,447,282	606,306	1 5%	Prescription drugs	75,949,443	78,203,769	2,254,326	2 9%
36,632,544	36,669,152	36,608	0 1%	MLTSS	71,678,114	73,179,021	1,500,907	2 1%
3,096,672	3,746,424	649,753	17 3%	Medical management	5,910,797	7,335,006	1,424,210	19 4%
934,337	530,634	(403,703)	(76 1%)	Reinsurance & other	1,604,257	1,061,268	(542,989)	(51 2%)
244,201,790	**236,996,787**	**(7,205,003)**	**(3.0%)**	**Total Medical Expenses**	**473,381,488**	**471,509,328**	**(1,872,160)**	**(0.4%)**
9,497,770	**10,394,138**	**(896,368)**	**(8.6%)**	**Gross Margin**	**19,493,761**	**22,169,274**	**(2,675,512)**	**(12.1%)**
				Administrative Expenses				
5,781,965	7,363,064	1,581,099	21 5%	Salaries, wages & employee benefits	11,896,970	14,324,012	2,427,042	16 9%
241,668	349,650	107,982	30 9%	Professional fees	351,134	699,299	348,165	49 8%
694,112	945,147	251,035	26 6%	Purchased services	1,375,770	1,892,789	517,019	27 3%
153,588	423,310	269,721	63 7%	Printing and postage	515,680	846,619	330,940	39 1%
392,048	462,075	70,027	15 2%	Depreciation and amortization	805,742	924,151	118,409	12 8%
1,190,141	1,494,214	304,073	20 4%	Other operating expenses	2,365,229	2,985,932	620,704	20 8%
(204,594)	(223,591)	(18,997)	(8 5%)	Indirect cost allocation, Occupancy Expense	(441,763)	(447,183)	(5,420)	(1 2%)
8,248,927	**10,813,868**	**2,564,941**	**23.7%**	**Total Administrative Expenses**	**16,868,763**	**21,225,620**	**4,356,858**	**20.5%**
				Operating Tax				
10,677,775	10,779,291	(101,515)	(0 9%)	Tax Revenue	21,346,813	21,563,429	(216,616)	(1 0%)
10,677,775	10,779,291	101,515	0 9%	Premium tax expense	21,346,813	10,779,291	(10,567,522)	(98 0%)
-	-	-	0 0%	Sales tax expense	-	10,784,138	10,784,138	100 0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
				Grant Income				
107,734	249,874	(142,140)	(56 9%)	Grant Revenue	131,731	499,748	(368,017)	(73 6%)
82,238	223,107	140,870	63 1%	Grant expense - Service Partner	94,988	446,214	351,227	78 7%
35,105	26,767	(8,338)	(31 1%)	Grant expense - Administrative	66,418	53,534	(12,884)	(24 1%)
(9,608)	-	(9,608)	**0.0%**	**Total Grant Income**	(29,674)	-	(29,674)	**0.0%**
0	**-**	**0**	**0.0%**	**QAF and IGT - Net**	**(0)**	**-**	**(0)**	**0.0%**
125	**-**	**125**	**0.0%**	**Other income**	**285**	**-**	**285**	**0.0%**
125	-	125	0 0%	MC Other income	285	-	285	0 0%
1,239,358	**(419,730)**	**1,659,089**	**395.3%**	**Change in Net Assets**	**2,595,609**	**943,653**	**1,651,955**	**175.1%**
96.3%	***95.8%***	***(0.5%)***	***(0.5%)***	***Medical Loss Ratio***	***96.0%***	***95.5%***	***(0.5%)***	***(0.6%)***
3.3%	***4.4%***	***1.1%***	***25.6%***	***Admin Loss Ratio***	***3.4%***	***4.3%***	***0.9%***	***20.4%***

Back to Agenda

MEDI-CAL INCOME STATEMENT – AUGUST MONTH:

REVENUES of $253.7 million are favorable to budget $6.3 million, driven by:

- Unfavorable volume related variance of $2.3 million
- Favorable price related variance of $8.6 million due to:
  - $4.7 million of prior year (PY) LTC revenue from non-LTC aid codes
  - $2.2 million of Proposition 56 revenue
  - $1.2 million of Applied Behavior Analysis (ABA) revenue
  - $1.0 million of Coordinated Care Initiative (CCI) revenue

MEDICAL EXPENSES are $244.2 million, unfavorable to budget $7.2 million due to:

- **Facilities** expense is unfavorable to budget $8.1 million due to inpatient claims totaling $3.2 million and an overall increase to reserve due to high volume of payments during the month
- **Provider Capitation** expense is unfavorable to budget $3.7 million due to Child Health and Disability Prevention (CHDP) of $2.8 million and Proposition 56 capitation expense
- **Professional Claims** expense is favorable to budget $3.7 million due to CHDP expenses of $1.9 million, professional claim expenses of$1.0 million, and Behavioral Health Treatment (BHT) expenses of $0.5 million
- **Prescription Drug** expense is favorable to budget $0.7 million
- **Managed Long Term Services and Supports (MLTSS)** expense is favorable to budget $0.6 million

ADMINISTRATIVE EXPENSES are $8.2 million, favorable to budget $2.6 million, driven by:

- **Salary & Benefits**: $1.6 million favorable to budget driven by 145 open positions
- **Printing and Postage**: $0.3 million favorable to budget
- **Other Non-Salary**: $0.7 million favorable to budget

CHANGE IN NET ASSETS is $1.2 million for the month, $1.7 million favorable to budget

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Two Months Ending August 31, 2018

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
13,137	**14,906**	**(1,769)**	**(11.9%)**	**Member Months**	**29,536**	**29,829**	**(293)**	**(1.0%)**
				Revenues				
2,690,143	3,352,567	(662,424)	(19 8%)	Medi-Cal Capitation revenue	5,240,425	6,732,927	(1,492,502)	(22 2%)
16,736,771	16,935,102	(198,331)	(1 2%)	Medicare Capitation revenue Part C	35,566,281	33,744,170	1,822,111	5 4%
7,560,435	4,698,754	2,861,681	60 9%	Medicare Capitation revenue Part D	13,160,748	9,404,420	3,756,328	39 9%
-	-	-	0 0%	Other Income	-	-	-	0 0%
26,987,349	**24,986,423**	**2,000,926**	**8.0%**	**Total Operating Revenue**	**53,967,454**	**49,881,517**	**4,085,937**	**8.2%**
				Medical Expenses				
12,810,979	11,346,087	(1,464,892)	(12 9%)	Provider capitation	24,973,134	22,625,080	(2,348,054)	(10 4%)
3,042,337	3,608,960	566,623	15 7%	Facilities	6,186,307	7,199,767	1,013,460	14 1%
608,841	653,273	44,432	6 8%	Ancillary	1,132,684	1,303,944	171,260	13 1%
1,584,958	1,720,542	135,584	7 9%	Long Term Care	2,716,385	3,456,469	740,084	21 4%
5,564,495	5,350,714	(213,781)	(4 0%)	Prescription drugs	11,170,202	10,693,273	(476,929)	(4 5%)
1,127,611	1,371,979	244,368	17 8%	Medical management	2,173,792	2,686,987	513,195	19 1%
200,000	148,491	(51,509)	(34 7%)	Other medical expenses	481,905	297,507	(184,398)	(62 0%)
24,939,221	**24,200,046**	**(739,175)**	**(3.1%)**	**Total Medical Expenses**	**48,834,410**	**48,263,027**	**(571,383)**	**(1.2%)**
2,048,127	**786,377**	**1,261,750**	**160.5%**	**Gross Margin**	**5,133,045**	**1,618,490**	**3,514,555**	**217.2%**
				Administrative Expenses				
722,036	919,585	197,549	21 5%	Salaries, wages & employee benefits	1,548,206	1,800,953	252,747	14 0%
4,166	42,917	38,751	90 3%	Professional fees	8,334	85,833	77,500	90 3%
201,187	251,415	50,228	20 0%	Purchased services	372,402	502,830	130,428	25 9%
60,686	86,202	25,515	29 6%	Printing and postage	100,406	172,403	71,997	41 8%
-	-	-	0 0%	Depreciation & amortization	-	-	-	0 0%
50,573	77,036	26,464	34 4%	Other operating expenses	96,001	154,073	58,072	37 7%
557,394	557,394	-	0 0%	Indirect cost allocation	1,114,788	1,114,788	-	0 0%
1,596,042	**1,934,549**	**338,506**	**17.5%**	**Total Administrative Expenses**	**3,240,137**	**3,830,880**	**590,743**	**15.4%**
				Operating Tax				
-	-	-	0 0%	Tax Revenue	-	-	-	0 0%
-	-	-	0 0%	Premium tax expense	-	-	-	0 0%
-	-	-	0 0%	Sales tax expense	-	-	-	0 0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
452,085	**(1,148,172)**	**1,600,257**	**139.4%**	**Change in Net Assets**	**1,892,907**	**(2,212,390)**	**4,105,298**	**185.6%**
92.4%	***96.9%***	***4.4%***	***4.6%***	***Medical Loss Ratio***	***90.5%***	***96.8%***	***6.3%***	***6.5%***
5.9%	***7.7%***	***1.8%***	***23.6%***	***Admin Loss Ratio***	***6.0%***	***7.7%***	***1.7%***	***21.8%***

Back to Agenda

ONECARE CONNECT INCOME STATEMENT – AUGUST MONTH:

REVENUES of $27.0 million are favorable to budget $2.0 million due to Medicare Part D revenue adjustments

MEDICAL EXPENSES of $25.0 million are unfavorable to budget $0.7 million due to additional capitation expense for calendar year (CY) 2018 risk adjustment reconciliation

ADMINISTRATIVE EXPENSES of $1.6 million are favorable to budget $0.3 million

CHANGE IN NET ASSETS is $0.5 million, $1.6 million favorable to budget

CalOptima
OneCare
Statement of Revenues and Expenses
For the Two Months Ending August, 31, 2018

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,384	**1,324**	**60**	**4.5%**	**Member Months**	**2,774**	**2,648**	**126**	**4.8%**
				Revenues				
152,691	1,118,743	(966,052)	(86.4%)	Medicare Part C revenue	972,433	2,154,033	(1,181,599)	(54.9%)
539,737	502,217	37,520	7.5%	Medicare Part D revenue	1,035,473	1,003,363	32,109	3.2%
692,428	**1,620,960**	**(928,532)**	**(57.3%)**	**Total Operating Revenue**	**2,007,906**	**3,157,396**	**(1,149,490)**	**(36.4%)**
				Medical Expenses				
96,631	458,601	361,970	78.9%	Provider capitation	450,167	884,922	434,755	49.1%
734,542	517,112	(217,430)	(42.0%)	Inpatient	1,159,099	1,030,276	(128,822)	(12.5%)
45,091	55,063	9,972	18.1%	Ancillary	57,926	109,536	51,610	47.1%
123,840	26,857	(96,983)	(361.1%)	Skilled nursing facilities	198,547	53,715	(144,833)	(269.6%)
345,685	445,081	99,395	22.3%	Prescription drugs	799,833	889,063	89,230	10.0%
39,260	34,759	(4,501)	(12.9%)	Medical management	116,327	69,011	(47,316)	(68.6%)
6,500	6,560	60	0.9%	Other medical expenses	13,000	13,118	118	0.9%
1,391,549	**1,544,033**	**152,484**	**9.9%**	**Total Medical Expenses**	**2,794,899**	**3,049,641**	**254,742**	**8.4%**
(699,122)	**76,926**	**(776,048)**	**(1008.8%)**	**Gross Margin**	**(786,993)**	**107,755**	**(894,747)**	**(830.4%)**
				Administrative Expenses				
133,387	133,887	500	0.4%	Indirect cost allocation, occupancy expense	193,964	266,135	72,170	27.1%
133,387	**133,887**	**500**	**0.4%**	**Total Administrative Expenses**	**193,964**	**266,135**	**72,170**	**27.1%**
(832,508)	**(56,961)**	**(775,548)**	**(1361.5%)**	**Change in Net Assets**	**(980,957)**	**(158,380)**	**(822,577)**	**(519.4%)**
201.0%	***95.3%***	***(105.7%)***	***(111.0%)***	***Medical Loss Ratio***	***139.2%***	***96.6%***	***(42.6%)***	***(44.1%)***
19.3%	***8.3%***	***(11.0%)***	***(133.2%)***	***Admin Loss Ratio***	***9.7%***	***8.4%***	***(1.2%)***	***(14.6%)***

Back to Agenda

CalOptima
PACE
Statement of Revenues and Expenses
For the Two Months Ending August, 31, 2018

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
286	**277**	**9**	**3.2%**	**Member Months**	**559**	**548**	**11**	**2.0%**
				Revenues				
1,599,037	1,551,547	47,490	3 1%	Medi-Cal capitation revenue	3,111,835	3,068,939	42,896	1 4%
377,089	366,464	10,625	2 9%	Medicare Part C revenue	796,860	726,341	70,519	9 7%
74,000	88,788	(14,788)	(16 7%)	Medicare Part D revenue	218,428	175,765	42,663	24 3%
2,050,126	**2,006,799**	**43,327**	**2.2%**	**Total Operating Revenue**	**4,127,123**	**3,971,045**	**156,078**	**3.9%**
				Medical Expenses				
628,133	728,517	100,384	13 8%	Medical management	1,149,231	1,366,379	217,148	15 9%
476,582	411,693	(64,889)	(15 8%)	Claims payments to hospitals	789,158	811,857	22,699	2 8%
405,916	442,393	36,477	8 2%	Professional claims	800,207	874,241	74,034	8 5%
175,311	123,484	(51,827)	(42 0%)	Patient transportation	348,152	244,293	(103,859)	(42 5%)
138,423	159,302	20,879	13 1%	Prescription drugs	286,947	314,627	27,680	8 8%
2,576	8,719	6,143	70 5%	MLTSS	830	16,111	15,281	94 8%
2,860	2,750	(110)	(4 0%)	Other expenses	5,590	5,450	(140)	(2 6%)
1,829,800	**1,876,858**	**47,058**	**2.5%**	**Total Medical Expenses**	**3,380,114**	**3,632,958**	**252,844**	**7.0%**
220,326	**129,941**	**90,385**	**69.6%**	**Gross Margin**	**747,009**	**338,087**	**408,922**	**121.0%**
				Administrative Expenses				
94,961	123,302	28,341	23 0%	Salaries, wages & employee benefits	185,723	223,672	37,949	17 0%
(2,576)	167	2,743	1645 6%	Professional fees	224	333	109	32 8%
14,285	21,027	6,742	32 1%	Purchased services	17,100	42,053	24,953	59 3%
6,401	10,428	4,027	38 6%	Printing and postage	6,401	20,857	14,455	69 3%
2,074	2,091	17	0 8%	Depreciation & amortization	4,148	4,181	33	0 8%
(8,482)	3,859	12,341	319 8%	Other operating expenses	(2,935)	7,717	10,653	138 0%
3,134	3,466	332	9 6%	Indirect cost allocation, Occupancy expense	6,234	6,931	697	10 1%
109,797	**164,338**	**54,541**	**33.2%**	**Total Administrative Expenses**	**216,895**	**305,746**	**88,850**	**29.1%**
				Operating Tax				
3,993	-	3,993	0 0%	Tax Revenue	7,804	-	7,804	0 0%
3,993	-	(3,993)	0 0%	Premium tax expense	7,804	-	(7,804)	0 0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
110,529	**(34,397)**	**144,927**	**421.3%**	**Change in Net Assets**	**530,114**	**32,341**	**497,772**	**1539.1%**
89.3%	***93.5%***	***4.3%***	***4.6%***	***Medical Loss Ratio***	***81.9%***	***91.5%***	***9.6%***	***10.5%***
5.4%	***8.2%***	***2.8%***	***34.6%***	***Admin Loss Ratio***	***5.3%***	***7.7%***	***2.4%***	***31.7%***

Back to Agenda

CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2018

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				
27,385	22,982	(4,403)	(19.2%)	Purchase services	60,947	45,963	(14,984)	(32.6%)
161,022	162,934	1,912	1.2%	Depreciation & amortization	322,438	325,869	3,431	1.1%
15,816	15,917	101	0.6%	Insurance expense	31,632	31,834	202	0.6%
119,093	173,136	54,043	31.2%	Repair and maintenance	200,454	346,272	145,818	42.1%
90,542	1,635	(88,907)	(5437.8%)	Other Operating Expense	150,779	3,270	(147,509)	(4511.0%)
(413,858)	(376,604)	37,254	9.9%	Indirect allocation, Occupancy	(766,250)	(753,208)	13,042	1.7%
0	**-**	**(0)**	**0.0%**	**Total Administrative Expenses**	**0**	**-**	**(0)**	**0.0%**
(0)	**-**	**(0)**	**0.0%**	**Change in Net Assets**	**(0)**	**-**	**(0)**	**0.0%**

Back to Agenda

OTHER STATEMENTS – AUGUST MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($832.5) thousand, $775.5 thousand unfavorable to budget due to CMS recoupment of $1 million for calendar year 2016 risk adjustment reconciliation

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $110.5 thousand, $144.9 thousand favorable to budget

CalOptima
Balance Sheet
August 31, 2018

ASSETS		LIABILITIES & FUND BALANCES	
Current Assets		Current Liabilities	
Operating Cash	$515,126,697	Accounts Payable	$27,340,664
Investments	384,790,436	Medical Claims liability	798,445,025
Capitation receivable	349,281,991	Accrued Payroll Liabilities	12,122,006
Receivables - Other	23,314,880	Deferred Revenue	109,018,787
Prepaid expenses	6,469,472	Deferred Lease Obligations	108,100
		Capitation and Withholds	109,884,755
Total Current Assets	**1,278,983,476**	**Total Current Liabilities**	**1,056,919,336**
Capital Assets			
Furniture & Equipment	34,328,849		
Building/Leasehold Improvements	8,216,084		
505 City Parkway West	49,743,943		
	92,288,876		
Less: accumulated depreciation	(42,121,609)		
Capital assets, net	50,167,267	Other (than pensions) post employment benefits liability	24,818,101
Other Assets		Net Pension Liabilities	24,979,118
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	100,000
Board-designated assets			
Cash and Cash Equivalents	11,807,176	**TOTAL LIABILITIES**	**1,106,816,554**
Long-term Investments	528,886,911		
Total Board-designated Assets	540,694,087	Deferred Inflows	
Total Other Assets	540,994,087	Change in Assumptions	3,329,380
TOTAL ASSETS	**1,870,144,830**	TNE	84,945,052
		Funds in Excess of TNE	686,186,894
Deferred Outflows			
Pension Contributions	953,907		
Difference in Experience	1,365,903	Net Assets	771,131,946
Excess Earnings	1,017,387		
Changes in Assumptions	7,795,853		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,881,277,880**	**TOTAL LIABILITIES & FUND BALANCES**	**1,881,277,880**

Back to Agenda

CalOptima
Board Designated Reserve and TNE Analysis
as of August 31, 2018

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	147,914,240				
	Tier 1 - Logan Circle	147,864,857				
	Tier 1 - Wells Capital	147,242,444				
Board-designated Reserve		443,021,541	317,442,949	489,894,949	125,578,593	(46,873,408)
TNE Requirement	Tier 2 - Logan Circle	97,672,546	84,945,052	84,945,052	12,727,494	12,727,494
	Consolidated:	**540,694,087**	**402,388,001**	**574,840,001**	**138,306,087**	**(34,145,914)**
	Current reserve level	1.88	1.40	2.00		

Back to Agenda

CalOptima

Statement of Cash Flows

August 31, 2018

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	4,484,266	9,500,379
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	557,056	1,132,329
Changes in assets and liabilities:		
Prepaid expenses and other	116,025	(172,126)
Catastrophic reserves		
Capitation receivable	208,636,375	(51,445,855)
Medical claims liability	(44,057,798)	(34,174,588)
Deferred revenue	20,309,368	(4,684,162)
Payable to providers	4,534,812	13,435,863
Accounts payable	10,495,552	20,805,578
Other accrued liabilities	(92,477)	118,681
Net cash provided by/(used in) operating activities	204,983,179	(45,483,901)
GASB 68 CalPERS Adjustments	(0)	(0)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Investments	52,215,869	195,508,512
Purchase of property and equipment	(436,104)	(541,346)
Change in Board designated reserves	(1,997,833)	(2,446,415)
Net cash provided by/(used in) investing activities	49,781,932	192,520,751
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	254,765,111	147,036,850
CASH AND CASH EQUIVALENTS, beginning of period	$260,361,586	368,089,847
CASH AND CASH EQUIVALENTS, end of period	**515,126,697**	**515,126,697**

Back to Agenda

BALANCE SHEET:

ASSETS decreased $3.7 million from July or 0.2%

- **Cash and Cash Equivalents** increased by $254.8 million due to 2 months of capitation payments received
- **Investments** decreased $52.2 million based upon the timing of the state and federal capitation receipts, transfers to investment managers, and their investing liquidity decisions
- **Net Capitation Receivables** decreased $208.6 million related to the receipt of the July and August capitation payments

LIABILITIES decreased $8.2 million from July or 0.7%

- **Medical Claims Liability** by line of business decreased $44.1 million due to reduction of DHCS overpayment and large medical claims paid during the month
- **Deferred Revenue** increased $20.9 million due to receipt of September's capitation payment
- **Capitation Payable** increased $4.5 million due increase in Risk Sharing reserve
- **Accrued Expenses** increased $10.0 million due to timing of sales tax reserve and payment

NET ASSETS are $771.1 million, an increase of $4.5 million from July

CalOptima Foundation
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2018
Consolidated

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
0	0	0	0.0%	**Total Operating Revenue**	0	0	0	0.0%
				Operating Expenditures				
0	6,184	6,184	100.0%	Personnel	0	12,368	12,368	100.0%
0	2,985	2,985	100.0%	Taxes and Benefits	0	5,970	5,970	100.0%
0	0	0	0.0%	Travel	0	0	0	0.0%
0	0	0	0.0%	Supplies	0	0	0	0.0%
0	0	0	0.0%	Contractual	0	0	0	0.0%
917	229,840	228,923	99.6%	Other	1,834	459,679	457,845	99.6%
917	239,009	238,092	99.6%	**Total Operating Expenditures**	1,834	478,017	476,183	99.6%
0	0	0	0.0%	**Investment Income**	0	0	0	0.0%
(917)	(239,009)	(238,092)	(99.6%)	**Program Income**	(1,834)	(478,017)	(476,183)	(99.6%)

Back to Agenda

CalOptima Foundation
Balance Sheet
August 31, 2018

ASSETS		**LIABILITIES & NET ASSETS**	
Operating cash	2,843,139	Accounts payable-Current	1,834
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	**2,843,139**	Grants-Foundation	0
		Total Current Liabilities	**1,834**
		Total Liabilities	1,834
		Net Assets	**2,841,305**
TOTAL ASSETS	**2,843,139**	**TOTAL LIABILITIES & NET ASSETS**	**2,843,139**

Back to Agenda

CALOPTIMA FOUNDATION - AUGUST MONTH

INCOME STATEMENT:

OPERATING REVENUE

- No activity

OPERATING EXPENSES

- Audit Fees $1.8 thousand

BALANCE SHEET:

ASSETS

- Cash of $2.8 million remains from the FY14 $3.0 million transferred by CalOptima for grants and programs in support of providers and community

LIABILITIES

- $1.8 thousand

NET INCOME is ($1.8) thousand YTD

Budget Allocation Changes
Reporting Changes for August 2018

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year

No Activity for August

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 parameter

Back to Agenda

Board of Directors Meeting
October 4, 2018

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare Connect

- Performance Measure Validation (PMV) Audit for Medicare-Medicaid Plans (MMPs):

  On May 21, 2018, CMS notified MMPs of upcoming efforts to validate that MMPs' reported data on performance measures are reliable, valid, complete, and comparable. The following elements will be validated for the 2017 measurement year for select core and state-specific performance measures:

  - MMP Core 2.1: Members with an assessment completed within 90 days of enrollment.
  - MMP CA 1.2: High-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the initial Health Risk Assessment (HRA).
  - MMP CA 1.4: Low-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the initial Health Risk Assessment (HRA).

  Validation activities will focus on enrollment and eligibility data processes, assessment and care plan completion processes, performance measure production, and primary source verification. CalOptima's PMV audit took place on September 17, 2018. CalOptima is in the process of responding to several document requests.

- 2018 Data Integrity Testing (*applicable to OneCare Connect and OneCare*):

  As part of its audit readiness efforts, CalOptima has engaged an independent auditing consultant to perform validation of its universes for completeness and accuracy for select Part C core operational areas based on the final 2017 CMS Medicare Parts C and D Program Audit Protocols and the 2017 CMS Program Audit Protocols for Medicare-Medicaid Plans (MMPs). The data integrity testing and remediation efforts are taking place from early August through October 2018.

Back to Agenda

- Compliance Program Effectiveness (CPE) Audit (*applicable to OneCare Connect and OneCare*):

  CalOptima is required to conduct an independent audit on the effectiveness of its Compliance program on an annual basis, and to share the results with its governing body. As such, CalOptima has engaged an independent consultant to conduct the audit to ensure that its Compliance Program is being administered effectively. CalOptima's Office of Compliance is currently preparing documents for the onsite audit scheduled for the week of September 24, 2018.

2. Medi-Cal

- 2018 Medi-Cal Audit:

  The Department of Health Care Services (DHCS) conducted its annual audit of CalOptima's Medi-Cal program from February 26, 2018 through March 9, 2018. The audit covered the period from February 1, 2017 through January 31, 2018. The audit consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and care coordination, access and availability, member rights and responsibilities, quality improvement system, organization and administration of CalOptima, facility site reviews, and medical records review. DHCS issued its draft audit report on August 27, 2018. The draft report contained only one (1) finding in the area of case management and care coordination. Specifically, DHCS cited that the "Plan did not ensure that Behavioral Health Treatment (BHT) services were provided and supervised under a Plan-approved behavioral treatment plan that included a transition plan, crisis plan, and parent/caregiver training." CalOptima will have fifteen (15) days from the date of the exit conference, which took place on August 30, 2018, to dispute the content of the draft report, if necessary. DHCS is expected to finalize its report and request a Corrective Action Plan (CAP) from CalOptima by October 1, 2018. CalOptima will have thirty (30) calendar days from the date of receipt, or no later than October 30, 2018, to respond to the CAP request.

B. Regulatory Notices of Non-Compliance

1. CalOptima did not receive any notices of non-compliance from its regulators for the month of August 2018.

C. Updates on Internal and Health Network Audits

1. Internal Audits: Medi-Cal, OneCare, OneCare Connect, and PACE

- For the months of June through August 2018 (based on data from May through July 2018), monthly file reviews for internal CalOptima departments were suspended due to the annual validation audits in progress. In lieu of the monthly file reviews, CalOptima's Audit & Oversight department conducted an annual validation audit, including a desk review of applicable policies and procedures, to ensure that deficiencies identified throughout the year have been remediated. Monthly file reviews for internal CalOptima departments will resume in September 2018 (based on August data). Final results from the annual validation

audit of internal CalOptima departments will be reported to the Board of Directors once available.

2. Health Network Audits: Medi-Cal

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgent	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
April 2018	88%	94%	93%	79%	81%	85%	91%	94%	94%	96%	82%	63%	87%
May 2018	70%	78%	79%	85%	78%	91%	88%	88%	88%	88%	43%	57%	76%
June 2018	81%	78%	82%	77%	78%	86%	88%	80%	81%	86%	33%	72%	66%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Routine – 5 business days; Deferral – 14 business days)
  - Failure to meet timeframe for member notification (2 business days)
  - Failure to meet timeframe for provider written notification (2 business days)
  - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)
  - Failure to meet timeframe for member delay notification (5 business days)
  - Failure to meet timeframe for provider delay notification (5 business days)

- The lower scores for clinical decision making were due to the following reasons:
  - Failure to cite criteria for decision
  - Failure to obtain adequate clinical information
  - Failure to have appropriate professional make decision

- The lower letter scores were due to the following reasons:
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide language assistance program (LAP) insert in approved threshold languages
  - Failure to provide member with information on how to file a grievance
  - Failure to provide letter in member's primary language
  - Failure to provide letter with description of services in lay language
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer
  - Failure to provide referral back to primary care provider (PCP) on denial letter
  - Failure to provide enrollee notice of delayed decision and anticipated decision date

  - Failure to provide notice to provider of delayed decision and anticipated decision date
  - Failure to include name and contact information for health care professional responsible for the decision to deny

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2018	95%	96%	96%	89%
May 2018	98%	99%	98%	85%
June 2018	93%	90%	98%	90%

  - The compliance rate for paid claims timeliness decreased from 98% in May 2018 to 93% in June 2018 due to untimely processing of multiple claims.

  - The compliance rate for paid claims accuracy decreased from 99% in May 2018 to 90% in June 2018 due to claims missing documents required for processing.

- Medi-Cal Claims: Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2018	76%	100%	100%	100%
May 2018	100%	100%	100%	100%
June 2018	100%	67%	100%	100%

  - The compliance rate for paid claims accuracy decreased from 100% in May 2018 to 67% in June 2018 due to a single claim missing documents required for processing.

3. Health Network Audits: OneCare

- OneCare Utilization Management: Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
April 2018	86%	67%	79%	88%	67%	100%	78%	91%
May 2018	80%	67%	81%	89%	84%	100%	75%	89%
June 2018	67%	100%	80%	100%	83%	100%	75%	90%

➢ The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for member oral notification (Expedited – 72 hours)
  - Failure to meet timeframe for provider notification (Expedited – 24 hours)
  - Failure to meet timeframe for decision (Expedited – 24 hours)

➢ The lower letter scores were due to the following reasons:
  - Failure to provide member with information on how to file a grievance
  - Failure to provide member with information regarding the right to expedited reconsideration
  - Failure to provide member with the right to submit additional information
  - Failure to use approved CMS template
  - Failure to use CalOptima logo
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide letter with description of services in lay language

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2018	96%	91%	100%	99%
May 2018	98%	98%	100%	98%
June 2018	100%	100%	93%	93%

- The compliance rate for denied claims timeliness decreased from 100% in May 2018 to 93% in June 2018 due to untimely processing of multiple claims.

- The compliance rate for denied claims accuracy decreased from 98% in May 2018 to 93% in June 2018 due to multiple claims missing documents required for processing.

4. Health Network Audits: OneCare Connect

- OneCare Connect Utilization Management: Prior Authorization Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds
April 2018	76%	72%	82%	75%	79%	86%	67%	89%	56%	72%	85%
May 2018	83%	50%	70%	85%	71%	63%	81%	85%	80%	66%	74%
June 2018	84%	84%	79%	81%	81%	58%	79%	80%	50%	67%	77%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Routine – 5 business days)
  - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)

- The lower scores for clinical decision making were due to the following reasons:
  - Failure to cite criteria for decision
  - Failure to obtain adequate clinical information

- The lower letter scores were due to the following reasons:
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide member with information on how to file a grievance
  - Failure to provide letter in member's primary language
  - Failure to provide letter with description of services in lay language
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer
  - Failure to include name and contact information for health care professional responsible for the decision to deny

- OneCare Connect Claims: Professional Claims

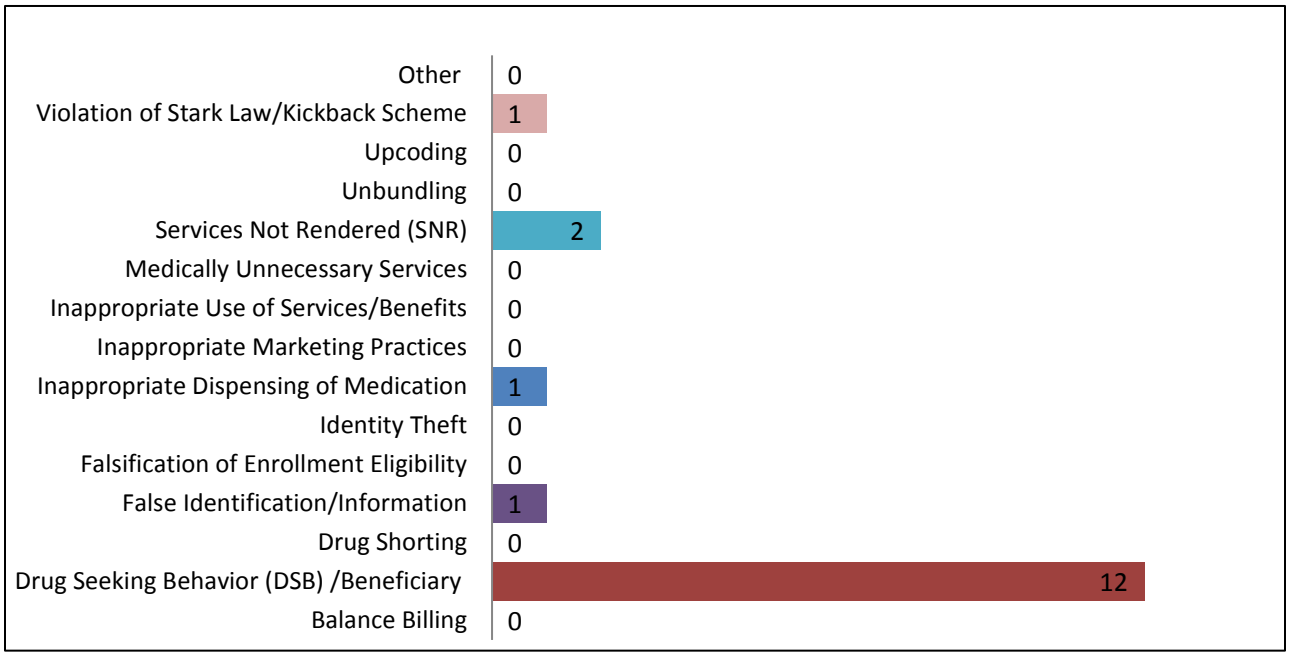
Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2018	90%	92%	98%	87%
May 2018	96%	97%	100%	79%
June 2018	94%	97%	99%	91%

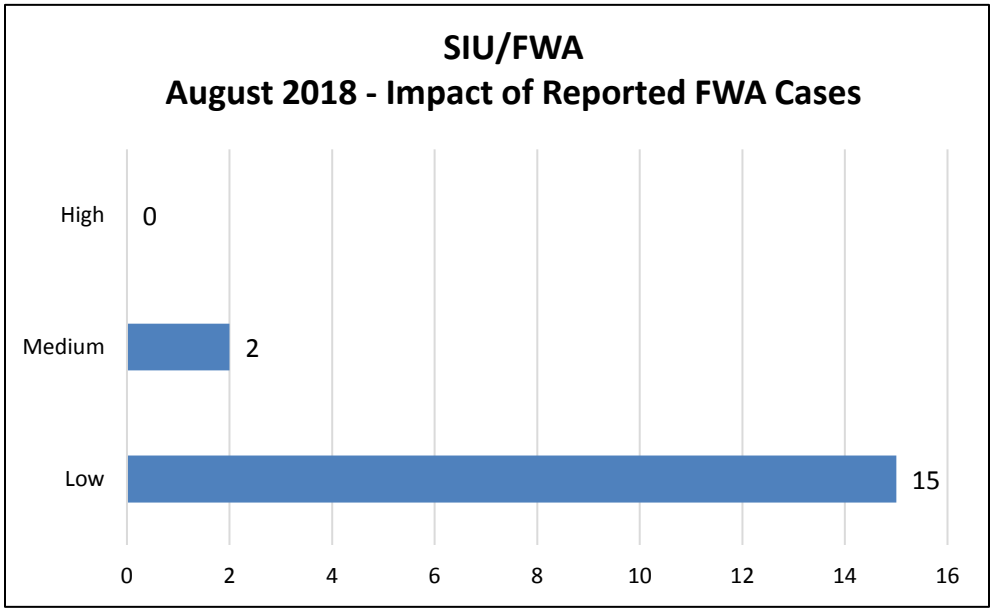
  - The compliance rate for denied claims timeliness decreased from 100% in May 2018 to 99% in June 2018 due to untimely processing of multiple claims.

  - The compliance rate for paid claims timeliness decreased from 96% in May 2018 to 94% in June 2018 due to untimely payment of multiple claims.

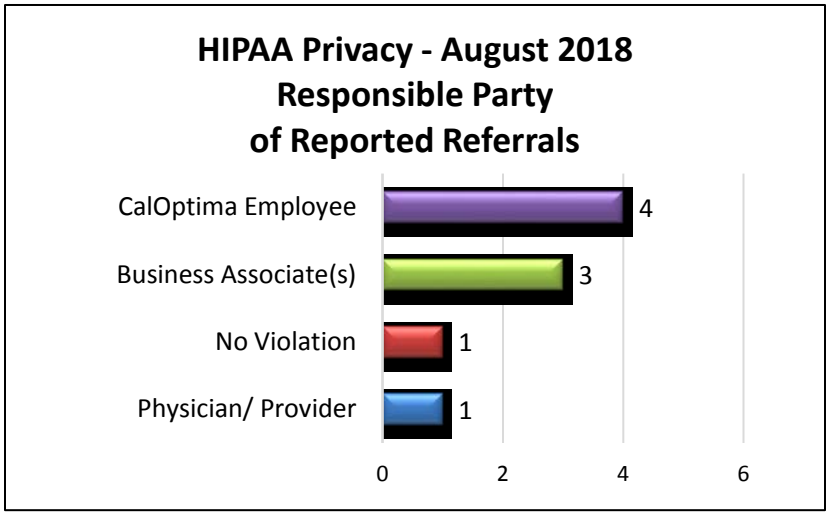
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

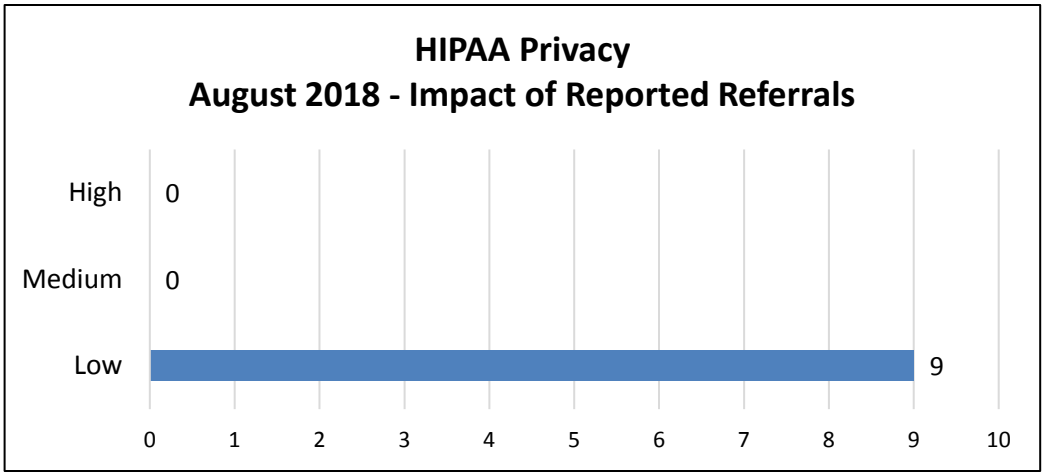
Types of FWA Cases: (Received in August 2018)





E. Privacy Update (August 2018)





PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	9
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**9**

A Public Agency

CalOptima

Better. Together.

Federal & State Legislative Advocate Reports

Board of Directors Meeting

October 4, 2018

Akin Gump Strauss Hauer & Feld / Edelstein Gilbert Robson & Smith

Back to Agenda

Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

September 12, 2018

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: September Board of Directors Report

With the House in recess through Labor Day, August was a relatively quiet month for Congress. Still, the Senate made progress on appropriations, nominations, and completed negotiations on an opioid response package. Appropriators now face a fast-approaching deadline to pass several government spending packages before the end of the fiscal year on September 30. Additionally, the Senate is expected to pass its own opioid package, though conference negotiations are likely to be completed after the midterm elections. This report provides an update on legislative activity through September 11, 2018.

Appropriations

Due to the confluence of several factors, both the House and Senate have made unusual progress in passing the 12 annual appropriations bills before the end of this fiscal year. In March 2018, President Trump only reluctantly signed an omnibus spending bill totaling more than $1 trillion after threatening to veto it earlier that same day. In order to avoid a repeat of this drama, Congressional Republicans developed and employed a strategy of packaging together several 'mini-bus' bills – bills that combine several appropriations bills rather than combining all 12 appropriations bills into a single omnibus appropriations bill. This breaks down the total price tag of a single bill, hopefully sidestepping some of the attention that the large March 2018 bill garnered among conservatives and conservative media outlets who oppose increased government spending. In addition, with 10 Senate Democrats up for re-election this year in states that President Trump won, the caucus was eager to secure funding wins for home-state constituents and demonstrate an ability to work across party lines, especially within the framework of higher spending secured earlier in the year. And, last, the Senate Republican leadership cancelled the August recess – partly to keep those vulnerable Senate Democrats from campaigning at home – creating the time on the schedule to work on passing these appropriations bills.

One of the more controversial appropriations bills each year is known as the Labor-H bill, which funds the Departments of Labor, Health and Human Services (HHS), Education, and other agencies. The bill is among the most controversial because it is where Democrats typically seek to increase funding while Republicans seek to cut it while trying to add policy provisions, such as banning funding for Planned Parenthood, that are vehemently opposed by Democrats. In an effort to avoid that controversy, Senate Appropriations Committee leaders paired the Labor-H

Back to Agenda

bill with the Defense appropriations bill, often considered a must-pass bill because it funds the military. On August 23, the Senate voted 85-7 to pass H.R. 6157, the Labor-H/Defense appropriations 'mini-bus'. The $179.3 billion Labor-HHS bill funds HHS at $90.1 billion and includes a $2 billion increase for the National Institutes of Health (NIH). The bill also contains $3.7 billion in funding for opioid response, with dollars going toward improving treatment and prevention; developing alternative pain therapies; and behavioral health services.

Several opioid-related amendments were added to the final package, including: an amendment from Sen. Bill Cassidy (R-LA) that would require the NIH to report to Congress on current funding levels related to mental health and substance use disorder; an amendment from Sen. Dean Heller (R-NV) that would provide additional funding for activities related to neonatal abstinence syndrome; and an amendment from Sen. Gary Peters (D-MI) to ensure that youth are considered when the Substance Abuse and Mental Health Services Administration (SAMHSA) follows guidance on the medication-assisted treatment for prescription drug and opioid addiction programs. Senators also adopted an amendment to implement rules that would require drug makers to disclose list prices in direct-to-consumer advertising.

Despite the progress in passing the appropriations bills, it is likely that a continuing resolution (CR) will still be needed to fund the government beyond September 30. It is likely that Labor-H and the contentious Homeland Security appropriations measures will be paired with a CR at the end of September. The Homeland Security appropriations bill is now among the most controversial because it is where funding for the President's long-promised border wall would be located. Although there has been unprecedented bipartisanship over considering appropriations bills via regular order, the limited days Congress is in session due to the midterm elections may cause Congress to rely on a CR and force much of the fall agenda into a post-election, Lame-duck session or even into 2019.

Meanwhile, President Trump continued to threaten a government shutdown later this month if Congress does not appropriate at least $5 billion for the construction of a U.S.-Mexico border wall. "If it's about border security, I'm willing to do anything," the President told reporters. House Speaker Paul Ryan (R-WI) has said, however, that Republican leaders and the President agree on the need to keep the government funded and avoid a shutdown shortly before the midterm elections. President Trump later said in an interview that he would wait until after elections to push for a budget showdown on the border wall.

Opioid Legislation

On September 6, Senate Health, Education, Labor and Pensions (HELP) Committee Chairman Lamar Alexander (R-TN) released the Senate's revised Opioid Crisis Response Act. The legislation will be considered as an amendment to the SUPPORT for Patients and Communities Act (H.R. 6), which the House passed in late June.

Notably, the Senate bill does not include language to amend 42 CFR Part 2 regulations, which govern the confidentiality of substance use disorder (SUD) patient records. Many have raised concerns that the current rules inhibit care coordination for SUD patients, and, to that end, the House passed legislation in June to align 42 CFR Part 2 requirements with Health Insurance Portability and Accountability Act (HIPAA) privacy rules. H.R. 6082, the Overdose Prevention and Patient Safety Act, has not been taken up by the Senate. In July, Akin Gump worked with CalOptima to draft and send letters to the California Senators, urging them to support the inclusion of H.R. 6082 in the Senate opioids package. Both Senators Feinstein and Harris co-sponsored companion legislation in the Senate, S. 1850, the Protecting Jessica Grubb's Legacy Act.

While H.R. 6 will be closed to further amendments when it comes to the Senate floor this week, there may be opportunities for stakeholders to modify a final opioid package during conference committee negotiations that will likely wrap up after the midterm elections.

PACE Regulations

This year, Akin Gump has worked closely with CalOptima and the National PACE Association to build support among the Congressional delegation representing Orange County for finalizing proposed regulations for the PACE program, including securing co-signers for Congressional letters and cosponsors for bills. On September 12, the House passed H.R. 6561, the Comprehensive Care for Seniors Act unanimously by voice vote. Demonstrating his support for the bill, Congressman Alan Lowenthal (D-CA-47) joined the bill as a cosponsor prior to the vote. And, Congresswoman Linda Sanchez (D-CA-38) supported approval of the bill in Committee on September 5. The bill directs the Centers for Medicare & Medicaid Services (CMS) to finalize proposed regulations regarding Programs of All-Inclusive Care for the Elderly (PACE), which provides in-home and community services for certain elderly individuals as an alternative to nursing home care. Specifically, the regulations would update and revise application, enforcement, and other administrative requirements under PACE. Rep. Jackie Walorski (R-IN) introduced the bill in July, after a bipartisan group of 69 Members of Congress sent a letter to CMS Administrator Seema Verma in June urging the agency to promulgate final regulations.

Back to Agenda

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate

CALOPTIMA LEGISLATIVE REPORT
By Don Gilbert and Trent Smith
September 10, 2018

The 2017-2018 Legislative Session came to an end on midnight, August 31. The legislative session spans two years. Bills that were not passed in the first year of the two-year session can be considered in the second year. However, bills that did not reach the Governor by August 31 are dead, although they can be reintroduced next year when a new legislative session begins.

Over the course of two years, approximately 5,600 bills were introduced. Last year, 1,189 bills were signed into law. This year, 1,562 bills reached the Governor's desk. While he has already signed or vetoed many of these bills, a majority of bills still await action by the Governor.

One of the bills passed to the Governor was AB 2275 by Assemblyman Arambula. This bill required the Department of Health Care Services (DHCS) to establish a quality assessment and performance improvement program for all Medi-Cal managed care plans. Health plans would have been required to meet a minimum performance level, effective January 1, 2021, that improved quality of care and reduced health disparities for beneficiaries. AB 2275 was sponsored by the Western Center on Law and Poverty. Many patient advocate groups supported the bill.

The California Association of Health Plans (CAHP) opposed AB 2275, arguing the bill could be administratively burdensome and costly without any clear benefit to improving care. The Department of Finance also opposed the bill, as it would have required new ongoing state expenditures to create, monitor, and analyze the performance standards established in the bill. The Governor vetoed AB 2275. In his veto message he stated that the bill was duplicative and added significant costs to Medi-Cal.

The Governor will have a similar decision to make on AB 2299 by Assemblyman Kansen Chu. This bill requires DHCS to ensure that all written health education and informing materials developed by Medi-Cal managed care plans in English or translated into threshold languages are at or below the equivalent of sixth grade reading level. This measure is also sponsored by the Western Center on Law and Poverty, and opposed by CAHP and the Department of Finance. CAHP argues that the bill includes unnecessary, repetitive, and costly steps for documents already translated by health plans. CAHP further argued that Medi-Cal managed care plans are currently required to provide health plan materials in a readability format, which means the documents are written at, or below sixth grade reading level. These requirements are contained in the contracts between health plans and DHCS. We believe there is a very good chance the Governor will veto AB 2299.

The Governor is more likely to sign AB 2472 by Assemblyman Wood. This bill requires the newly created Council on Health Care Delivery Systems to prepare a feasibility analysis of a public health insurance plan option, also known as a public option. Previous versions of AB

2472 would have required Medi-Cal managed care plans serving counties where there are less than two plans participating in the public healthcare exchange, to negotiate with Covered

California to become a new exchange plan. This provision was eventually amended out of the bill. However, the author and sponsors hope that the study required in AB 2472 will lead to solutions to provide more health care insurance options in certain underserved counties.

SB 1108 by Senator Hernandez is another bill aimed at expanding, or perhaps protecting, access to health care. This bill allows California to seek waivers from the federal government to increase enrollment in Medi-Cal. More significantly, SB 1108 prohibits California from requiring anyone on Medi-Cal to work in order to receive benefits. Kentucky, this year, attempted to add work requirements to the state's Medicaid program, but a judge blocked the action. SB 1108 was pursued in response to fears by some in California that the federal government could impose work requirements as a condition to be eligible for Medicaid.

Another bill attempting to preempt federal action is AB 2499 by Assemblyman Arambula. AB 2499 requires health plans to spend at least 80 percent of their expenditures on health care. The federal government has floated increasing the ratio insurers are allowed to spend on profits and administrative care. While it is unclear if AB 2499 or SB 1108 will prevent the federal government from imposing new Medicaid requirements, we do expect the Governor to sign both bills, if for no other reason but to send a clear political message regarding the strong principles that California holds regarding health care coverage.

AB 315 by Assemblyman Wood was a bill amended very late in the legislative process to impose regulations on pharmacy benefit managers (PBMs). PBMs are not regulated in a manner comparable to other health care services. Among the many changes proposed in the bill is a requirement that all PBMs register with the Department of Managed Health Care. It also requires PBMs to exercise good faith and fair dealing. More significantly, the bill requires pharmacies to disclose, upon a purchaser's request, information with respect to retail and purchase prices, as well as discounts provided by the PBM. AB 315 also establishes a pilot program in Solano and Riverside Counties prohibiting PBMs from requiring the use of mail order to receive prescription drugs. Originally, the intent was to apply this prohibition state-wide, but the sponsors and author quickly realized such a policy was not politically possible. AB 315 also creates a working group to study and consider additional changes in the prescription drug delivery network.

Labor unions, the California Medical Association, independent pharmacists, and patient advocacy groups support AB 315. Health plans oppose the bill. Surprisingly, the PBMs did not openly oppose the bill. It will be interesting to see what action the Governor takes on AB 315. Regardless whether he signs or vetoes the bill, we believe the issue of PBM reform will receive the attention of the Legislature on 2019.

Back to Agenda

2017–18 Legislative Tracking Matrix

FEDERAL BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
H.R. 6 Walden	**Opioids – Prescription Controls, Education/Prevention, and Provider Incentives:** The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act is a bipartisan effort in response to the national opioid crisis. The bill includes a broad range of provisions from multiple bills that were previously advanced through the House Energy and Commerce and Ways and Means Committees. There are several provisions relevant to the Medicaid and Medicare programs, including proposals to implement controls on pharmaceuticals to prevent inappropriate dispensation of opioids, expand access to effective addiction treatment, increase opioid misuse education and prevention efforts, and provide incentives to discourage physicians from over prescribing opioids.	**06/26/2018** Read in the Senate and placed on the Senate Legislative Calendar **06/22/2018** Passed the House **06/13/2018** Introduced	Watch
H.R. 6561 Walorski	**Programs of All-Inclusive Care for the Elderly (PACE) Final Rule:** Would direct the Secretary of Health and Human Services (HHS) to release the final PACE rule no later than December 31, 2018. The final rule would implement the first regulatory update to PACE regulations in more than ten years. The proposed changes include allowing PACE organizations (POs) to, (1) include community physicians as part of their hallmark interdisciplinary teams (IDTs); (2) use nurse practitioners and physician assistants as primary care providers; (3) provide services in settings other than the PACE Center, and; (4) configure the IDT to meet the needs of individual participants. Taken together these changes are likely to enable POs to accommodate more participants and expand their programs without compromising quality of care. CalOptima PACE has been an early adopter of many of these PACE innovations, applying for CMS exemptions to utilize community-based physicians, nurse practitioners, and the Alternative Care Setting (ACS) model to deliver PACE care outside of the PACE center.	**09/10/2018** Passed House, ordered to Senate **07/26/2018** Introduced and referred to the Committee on Ways and Means, and to the Committee on Energy and Commerce	Watch CalOptima provided feedback to members of OC congressional delegation
H.R. 6082 Mullin	**Confidentiality Regulations:** Would align the federal Confidentiality of Substance Use Disorder Patient Records regulations (42 USC 290dd-2 and 42 CFR Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) as they relate to the disclosure of substance use disorder (SUD) treatment. This bill would authorize the disclosure of SUD patient records to a covered entity, such as CalOptima, for treatment, payment, and health care operations without a patient's written consent, which is required under current law. This change would simplify the process of coordinating behavioral and physical health services by allowing health plans and providers treating the same patient to access their member's SUD treatment information.	**06/21/2018** Referred to the Senate Committee on Health, Education, Labor, and Pensions **06/13/2018** Introduced	Watch CalOptima provided feedback to members of OC congressional delegation

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
H.R. 4957 Sanchez	**Improving Alzheimer's Care:** Among other provisions, would establish Alzheimer's models of care based on a comprehensive continuum of care, similar to care delivery in the Program of All-Inclusive Care for the Elderly (PACE).	**02/13/2018** Referred to House Committee on Ways and Means Subcommittee on Health **02/07/2018** Introduced in the House	Watch
H.R. 1625 Royce	**FY 2018 Federal Budget/Omnibus Spending Bill:** Funds the federal government for the remainder of the 2018 budget year, through September 30. The bill includes: • $1.3 trillion in overall spending • $403 billion in Medicaid spending (an increase of $25 billion or 7 percent, accounting for 1.8 million more Medicaid beneficiaries and an increase in opioid related funding, among other factors) • $3.6 billion for opioid-addiction and mental health services (an increase of $2.55 billion or 244 percent) Of note, the bill did not include any stabilization measures for the individual market, such as the cost-sharing reduction payments or a federal reinsurance program.	**03/22/2018** Signed into law	Watch
H.R. 1892 Larson	**FY 2018 Federal Budget/Previous Spending Levels Continued:** • Establishes a two-year budget framework and continues current federal spending levels until March 23, 2018. • Permanently reauthorizes Dual Eligible Special Needs Plans (including CalOptima's OneCare program). • Extends reauthorization for the Children's Health Insurance Program (CHIP) until 2027. • Extends the Community Health Center Fund (CHCF) for two years.	**02/09/2018** Signed into law	CalOptima sent letter of support for CHIP, D-SNP and CHCF
H.R. 195 Russell	**FY 2018 Federal Budget/Previous Spending Levels Continued:** Extends current federal discretionary spending until February 8, 2018. Also authorizes CHIP funding for six years, until 2023, and gradually phases down the enhanced federal matching rate – 88/12 federal/state, to the regular CHIP rate – 65/35 federal/state in FY 2021.	**01/22/2018** Signed into law	CalOptima sent letter of support for CHIP
H.R. 1 Brady	**Tax Cuts and Jobs Act:** Amends portions of the Internal Revenue Code that address corporate and individual tax rates and deductions. It also eliminates the Affordable Care Act's (ACA) individual mandate, effective December 31, 2018.	**12/22/2017** Signed into law	Watch
H.R. 3922 Walden	**Five Year CHIP Re-authorization:** Would have extended federal CHIP funding, which expired on September 30, 2017, for five years. Would have retained the current ACA mandated state/federal CHIP matching rate (88/12 for California) for two years, reduced it by 11.5 percent for one year (76.5/23.5), and reverted to pre-ACA levels for two years (65/35). Also included spending offsets such as increasing Medicare premiums for beneficiaries who make more than $500,000 annually, requiring Medicaid beneficiaries to report lottery winnings as income, and decreasing funding for the ACA-enacted Prevention and Public Health Fund. Of note, H.R. 1892, referenced above, extends federal CHIP funding until 2027, and was signed into law on 02/09/2018.	**11/03/2017** Passed House, ordered to Senate **02/09/2018** 10-year reauthorization of CHIP funding included as part of H.R. 1892 (Larson)	CalOptima sent letter of support for CHIP

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
H. Concurrent Resolution 71 Black	**FY 2018 Budget Resolution:** The annual budget resolution sets the budgetary framework for the upcoming fiscal year and allows Congress to pass reconciliation legislation, which requires 51 votes to pass the Senate rather than the normal 60-vote threshold. While the budget resolution is non-binding and does not appropriate federal dollars, it does outline spending priorities for the remainder of the unfunded fiscal year (December 9, 2017 - September 30, 2018).	**10/26/2017** Passed House and Senate (Budget resolutions do not require a Presidential signature)	Watch
H.R. 601 Lowey	**FY 2018 Federal Budget/Previous Spending Levels Continued:** Extends current federal discretionary spending ($1.24 trillion overall) and raises the debt ceiling through December 8, 2017. Ensures funding for federal agencies such as the U.S. Department of Health and Human Services (HHS) continues at approximately $65 billion per year. Mandatory spending ($2.54 trillion overall) for programs such as Medicare and Medicaid continues at previous levels, less a small percentage, as required by the terms of the Budget Control Act of 2011.	**09/08/2017** Signed into law	Watch
Bipartisan Health Care Stabilization Act of 2017 Alexander/ Murray	**Marketplace Stabilization:** Would fund cost-sharing reductions (CSRs) – federal payments to marketplace insurers to reduce deductibles and co-pays for consumers earning between 139-250 percent of the federal poverty level (FPL) who have a "silver" level plan – through 2019. Also, would increase flexibility and streamline the state waiver approval process, among other changes. While this bill does not impact Medicaid directly, it is of interest to CalOptima because of its impact on the health care system, and, because it is common for Medicaid members to "churn" between Medicaid and the individual market.	**10/19/2017** Draft bill text released	Watch
S. 1804 Sanders	**Medicare for All:** Would replace the current U.S. health care system with a single-payer system, known as "Medicare for All." This system would provide comprehensive health care services for all U.S. residents, sunset the current Medicare and Medicaid programs, as well as most forms of private insurance, and enroll all eligible individuals into the new universal plan.	**09/13/2017** Referred to Senate Committee on Finance	Watch
H.R. 676 Ellison	**Medicare for All:** Similar to S. 1804, would replace the current U.S. health care system with a single-payer system, known as "Medicare for All." This system would provide comprehensive health care services for all U.S. residents, sunset the current Medicare and Medicaid programs as well as most forms of private insurance. The program would be funded via existing sources of government revenues for health care and by increasing personal income taxes on the top five percent of income earners, among other measures.	**01/24/2018** Referred to House Committee on Energy and Commerce, House Committee on Ways and Means, and the House Committee on Natural Resources	Watch

STATE BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
SB 840 Mitchell	**Budget Act of 2018:** Funds the state government for the 2018-2019 fiscal year. The Medi-Cal allocation is $104.4 billion, including $23 billion general fund. The following allocations impact the Medi-Cal program: • Medi-Cal Expansion Population: $18.7 billion ($1.7 billion GF) • Coverage for children regardless of immigration status: $365.2 million ($287.7 million GF) • Breast and Cervical Cancer Treatment Coverage: $8.4 million GF • Supplemental Provider Payment: $710 million (from Proposition 56) *The Budget Act is the predominant method by which appropriations are made to fund the state government. A budget bill is introduced by January 10 and the Legislature is required to pass the budget bill by June 15. The Budget Bill becomes the Budget Act upon the Governor's signature.*	**06/27/2018** Signed into law by the Governor	Watch
SB 856 Senate Budget Committee	**Junior Budget Bill:** Makes changes and corrections to the Budget Act of 2018, such as appropriating Proposition 56 tobacco tax revenue and related federal funds for Medi-Cal, among other provisions. This bill allocates up to $500 million for supplemental payments for physician services and directs the Department of Health Care Services (DHCS) to develop the methodology for distributing these payments as well as post the proposed payment structure on its website by September 30, 2018. *The Junior Budget Bill is the method by which amendments are made to the chaptered Budget Act.*	**06/27/2018** Signed into law by the Governor	Watch
SB 849 Senate Budget Committee	**Medi-Cal Trailer Bill:** Budget trailer bill that makes appropriations related to Proposition 56 supplemental payments (in conjunction with SB 856) and creates a dental integration pilot program in San Mateo County (carving dental into managed care), among other provisions. *When budget changes proposed by the Governor require changes to existing law, the legislation introduces separate legislation, referred to as "trailer bills," which are heard concurrently with the Budget Bill.*	**06/27/2018** Signed into law by the Governor	Watch
SB 850 Senate Budget Committee	**Homeless Emergency Aid program and Orange County Shelter:** Would establish the Homeless Emergency Aid program to provide local governments with one-time flexible block grant funds to address their immediate homelessness challenges. The bill would require the Business, Consumer Services, and Housing Agency to allocate a total of $500 million among local governments, with funding allocated according to homeless point-in-time counts, proportionate share of total homeless population, as well as direct allocations to cities and counties with populations over 330,000. This bill would also require DHCS to allocate $5 million to the Bridges at Kraemer Place emergency shelter in Orange County to create a homeless navigation center.	**06/27/2018** Signed into law by the Governor	Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
RN 1802014 Trailer Bill – 340B Drug Program	**340B Drug Purchasing Program:** Would prohibit the use of 340B discounted drugs in Medi-Cal starting July 1, 2019, pending approval from CMS. Section 340B of the Public Health Service Act allows certain hospitals and clinics to purchase pharmaceuticals at discounted prices. Federal and state agencies have found inconsistencies with the program's implementation. According to DHCS, these inconsistencies create a substantial administrative burden on the state. As such, the Department's proposed trailer bill language seeks to prohibit the use of 340B drugs in Medi-Cal. In the event that CMS does not grant the state permission to entirely exclude 340B drugs from Medi-Cal, the state will seek CMS approval for limiting the use of 340B drugs in Medi-Cal. Although this trailer bill language was not included in the final Budget deal, DHCS is likely to continue efforts to reform the 340B program through the regulatory process.	**05/15/2018** Heard in Senate Budget Subcommittee No. 3: Health and Human Services **01/16/2018** Trailer bill language published on the Department of Finance website	Watch CalOptima provided feedback as part of the CAHP and LHPC comment letters to DHCS
AB 2331 Weber	**Medi-Cal Eligibility Redetermination:** Would allow developmentally disabled individuals receiving services at regional centers to remain continuously eligible for Medi-Cal. Rather than the beneficiary being responsible for ensuring that annual redetermination is performed, counties will use information provided by the California Department of Developmental Services (DDS) and DHCS to ensure that they meet Medi-Cal eligibility criteria.	**05/25/2018** Held under submission in Assembly Appropriations Committee **02/13/2018** Introduced	CalOptima sent letter of support LHPC: Support
AB 1963 Waldron	**Opioids – Treatment:** Would increase provider reimbursement rates for Medication-Assisted Treatments (MAT). MAT requires that patients receive counseling, behavioral therapies, and recovery support services in combination with prescribed medication, such as buprenorphine/naloxone, methadone, buprenorphine, and naltrexone. These therapies have proven to be very effective in treating opioid addiction. There is a significant shortage of providers certified to administer MAT treatments. Depending on how the reimbursement structure is constructed, a rate increase could potentially help CalOptima expand access to MAT services in Orange County.	**05/25/2018** Held under submission in Assembly Appropriations Committee **01/30/2018** Introduced	Watch CalOptima provided feedback to the bill author
AB 2741 Burke	**Opioids – Supply Limit:** Would prohibit providers from prescribing more than a five-day opioid supply to a minor, except in the case of pain associated with cancer, palliative or hospice care, chronic pain, and emergency services and care; and require parental consent for opioid prescriptions.	**06/18/2018** Held in the Senate Business, Professions and Economic Development Committee at the request of the author **05/07/2018** Passed Assembly Floor and ordered to the Senate **02/16/2018** Introduced	Watch CalOptima provided feedback to the bill author

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 1998 Rodriguez	**Opioids – Prescription Controls:** Would institute more stringent prescription controls related to opioids, including limiting opioid prescriptions to amounts sufficient for not more than three days. *Bills which are determined to exceed a cost impact of $150,000 are placed on "suspense file" to be heard by the Appropriations Committees at the suspense file hearing towards the end of the legislative cycle. If the bill moves out of the suspense file, it proceeds to the floor for a vote while bills held on suspense die.*	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/30/2018** Passed Assembly Floor and ordered to the Senate **02/01/2018** Introduced	Watch
AB 2430 Arambula	**Medi-Cal Eligibility for Seniors:** Would adjust the income threshold for seniors eligible for Medi-Cal under the Aged and Disabled Federal Poverty Level Program from 123 percent FPL to 138 percent FPL, bringing it in line with other Medi-Cal programs for adult beneficiaries. Currently, seniors with income levels above 123 percent FPL are only eligible for Medi-Cal if they pay an added out of pocket expense known as "share of cost." Under share of cost, beneficiaries must take full responsibility for health care expenses up to a predetermined amount (share of cost) for the month in which they receive services. Once they meet their share of cost, Medi-Cal pays for any additional covered services for that month. This bill aims to ensure that low-income seniors have access to Medi-Cal at the same income level as most other adult beneficiaries, without incurring extra financial burdens.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/29/2018** Passed Assembly Floor and ordered to the Senate **02/14/2018** Introduced	Watch CAHP: Support LHPC: Support
SB 945 Atkins	**Breast and Cervical Cancer Treatment Program (BCCTP):** Would remove the 18 to 24-month cap on coverage under the state Breast and Cervical Cancer Treatment Program (BCCTP), which would allow members to remain in the program and CalOptima to continue receiving adequate reimbursement for the duration of their treatment. Currently, DHCS administers BCCTP, which provides cancer treatment coverage to individuals diagnosed with breast and/or cervical cancer that meet certain screening and income eligibility criteria. Currently, for individuals enrolled in the state BCCTP program, treatment coverage is limited to 18 months for breast cancer and 24 months for cervical cancer. Provisions from SB 945 were included as trailer bill language in AB 1810 (Committee on Budget, Assembly) which was signed into law eliminating the treatment term limits. The Budget includes $8.4 million General Fund allocation for this purpose.	**06/26/2018** Held in the Assembly Health Committee at the request of the author **05/29/2018** Passed Senate Floor and ordered to the Assembly **01/29/2018** Introduced	Watch LHPC: Support

2017–18 Legislative Tracking Matrix *(continued)*

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2275 Arambula	**Medi-Cal Quality Requirements:** Would create new quality requirements for Medi-Cal managed care plans, which would be a significant departure from the state's current quality assurance and performance improvement program. Amended language allows National Committee for Quality Assurance (NCQA) accredited plans, like CalOptima, to submit survey data collected annually as part of the NCQA accreditation. *After bills are passed by the Legislation and are presented to the Governor, he has until September 30, 2018 to sign or veto bills, or he can choose to take no action, in which case a bill would become chaptered without his signature immediately after the September 30 deadline. A chaptered bill becomes effective January 1, 2019 unless it contains an urgency clause or specifies its own effective date.*	**09/12/2018** Vetoed by the Governor **09/06/2018** Sent to the Governor's Desk **08/28/2018** Assembly concurred in Senate amendments **02/13/2018** Introduced	Watch CAHP: Oppose LHPC: Oppose CalOptima provided feedback to the bill author
AB 2299 Chu	**Materials for Medi-Cal Members:** Requires all Medi-Cal managed care plans' (MCPs) written health education and informational materials to meet a readability and suitability checklist established by DHCS. Informational materials would also be required to go through a "community review" process prior to submission to DHCS. Under current state policy, MCPs are already required to meet readability and suitability standards for all written materials. Currently, CalOptima's Health Education and Cultural Linguistic Services departments already review all informational materials released to members in all threshold languages. This bill would add an additional step – the community review – to the current process. This additional step could delay the release of member materials for an additional 45 days. According to analysis conducted by staff, while the intent of the bill appears to benefit members, these added requirements would create unnecessary delays in releasing information to members.	**09/05/2018** Sent to the Governor's Desk **08/27/2018** Assembly concurred in Senate amendments **02/13/2018** Introduced	Watch CAHP: Oppose LHPC: Oppose CalOptima provided feedback to the bill author
AB 2579 Burke	**WIC to Medi-Cal Express Lane:** Would establish an "express lane" eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to Medi-Cal. WIC is a federally funded program that provides supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and infants and children up to age five. The bill intends to leverage the similarity between WIC and Medi-Cal eligibility rules, to ensure that uninsured children and pregnant women who are eligible for Medi-Cal are able to conveniently enroll in the program.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/30/2018** Passed Assembly Floor and ordered to the Senate **02/15/2018** Introduced	Watch CAHP: Support LHPC: Support
AB 2193 Maienschein	**Maternal Mental Health Program:** Would require health plans to develop a maternal mental health program to address mental health conditions that occur during pregnancy or postpartum period. Upon analysis by staff, CalOptima's Comprehensive Perinatal Services Program (CPSP) appears to comply with the requirements of the bill, as currently written, as these overlap with existing standards and requirements in Medi-Cal managed care contracts.	**09/06/2018** Sent to the Governor's Desk **08/29/18** Assembly concurred in Senate amendments **02/12/2018** Introduced	Watch CalOptima provided feedback to LHPC

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
SB 1125 Atkins	**Access to Mental Health at FQHCs:** Would allow a Federally Qualified Health Center (FQHC) to be reimbursed by the state for a mental health visit that occurs on the same day as a medical face-to-face visit. Currently, a patient must seek mental health treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would give members access to both primary care and on-site mental health care on the same day, while ensuring that clinics are appropriately reimbursed for both services. Currently, approximately 138,000 CalOptima members receive care at FQHCs.	**08/31/2018** Senate concurred in Assembly amendments **08/31/2018** Passed the Assembly and ordered back to the Senate for concurrence in Assembly amendments **02/13/2018** Introduced	CalOptima sent letter of support LHPC: Support
AB 2029 Garcia	**Billable Visits for Service Outside the FQHC's Four Walls:** Among other provisions, this bill would align state and federal regulations to allow FQHCs to bill for services provided to CalOptima members outside the FQHC's four walls. Current federal law allows FQHCs to provide services to patients at temporary shelters, a beneficiary's residence, a location of another provider, or any location approved by the U.S. Health Resources and Services Administration (HRSA). Allowing FQHCs to bill for services outside their four walls would expand access to care for CalOptima members who are homebound, require specialized transportation or reside in temporary shelters.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **02/05/2018** Introduced	Watch CalOptima provided feedback as part of LHPC comment letter to the bill author
AB 2965 Arambula	**Medi-Cal Eligibility:** Extends full scope Medi-Cal coverage to eligible individuals who are under 26 years of age, regardless of immigration status.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/30/2018** Passed Assembly Floor and ordered to the Senate **02/16/2018** Introduced	Watch CAHP: Support LHPC: Support
SB 974 Lara	**Medi-Cal Eligibility:** Extends full scope Medi-Cal coverage to eligible individuals who are 65 years of age or older, regardless of immigration status.	**08/16/2018** Held in Assembly Appropriations Committee Suspense File **05/30/2018** Passed Senate Floor and ordered to the Assembly **02/01/2018** Introduced	Watch LHPC: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2718 Friedman	**Transitional Medi-Cal Eligibility for CalWORKs Recipients:** Extends Medi-Cal eligibility from six months to twelve months for families transitioning off the California Work Opportunity and Responsibility to Kids program (CalWORKs). Current state policy allows for a six-month extension of coverage after a family exits the program, and an additional six months if their income remains at or below 185 percent FPL. This bill would allow families to retain access to Medi-Cal coverage for twelve months, regardless of income, by requiring the state to implement the federally allowable twelve-month period option.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/30/2018** Passed Assembly Floor and ordered to the Senate **02/15/2018** Introduced	Watch
AB 2203 Gray	**Medi-Cal Provider Rates:** Beginning July 1, 2019, would require DHCS to increase Medi-Cal primary care provider rates to the rate paid for those services under the federal Medicare program.	**05/25/2018** Held under submission in Assembly Appropriations Committee **02/12/2018** Introduced	Watch
AB 2122 Reyes	**Pediatric Blood Lead Testing:** Would require DHCS to notify parents of children enrolled in Medi-Cal of lead testing requirements and inform them when their children have missed the test. Under current law, children are to be tested at 12 months of age and again at 24 months. This bill would require DHCS to report its progress in meeting the lead testing requirements on an annual basis. Medi-Cal managed care plans would be required to notify and educate health care providers that fail to blood test at least eighty percent of enrolled children. According to the bill language, a disproportionate number of children who test positive for lead-poisoning are enrolled in Medi-Cal.	**09/10/2018** Sent to the Governor's Desk **08/30/2018** Assembly concurred in Senate amendments **08/23/2018** Passed Senate and ordered back to the Assembly for concurrence in Senate amendments **02/08/2018** Introduced	Watch CalOptima provided feedback to the bill author
AB 2472 Wood	**Medi-Cal Public Option Feasibility Study:** Would require Covered California to prepare a feasibility study to assess the possibility of establishing a public health insurance plan. The plan would permit individuals whose income is greater than 138 percent of the federal poverty level to purchase Medi-Cal coverage. Among other requirements, the study would explore the feasibility of allowing Medi-Cal managed care plans to negotiate with Covered California regarding offering products on the California Health Benefit Exchange in counties where only two or fewer plans are available for purchase through the Exchange.	**09/05/2018** Sent to the Governor's Desk **08/27/18** Assembly concurred in Senate amendments **08/22/18** Passed the Senate and ordered back to the Assembly for concurrence in Senate amendments **02/14/2018** Introduced	Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 3175 Rubio	**Child Life Specialist:** Would require that services provided by certified child life specialists be covered under the California Children's Services (CCS) program. CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with specialized health care conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, among others. CCS-eligible children living in select counties, including Orange County, will transition from fee-for-service to Medi-Cal managed care as part of the Whole Child Model (WCM), established as part of SB 586 (Chapter 625, Statutes of 2016). In Orange County, the CCS WCM transition is scheduled to take place in January 2019. Certified child life specialists are allied health care professionals that support children and families coping with the stress and uncertainty of life altering healthcare crises.	**05/25/2018** Held under submission in Assembly Appropriations Committee **02/16/2018** Introduced	Watch
SB 906 Beall	**Medi-Cal Mental Health Services Peer Certification:** Would require DHCS to establish a statewide certification program for peer and family support specialists and to include as a service to be reimbursed under the Medi-Cal program. Among other responsibilities, a peer and family support specialist would provide individualized support services to members with mental health care needs and substance use disorders.	**08/31/2018** Senate concurred in Assembly amendments **08/31/2018** Passed the Assembly and ordered back to the Senate for concurrence in Assembly amendments **05/30/2018** Passed Senate Floor and ordered to the Assembly **01/17/2018** Introduced	Watch
SB 399 Portantino	**Autism Spectrum Disorder Treatment:** Would make changes to current law related to the treatment of Autism Spectrum Disorder, such that managed care plans would be required to cover certain treatment protocols that are not currently covered, such as the Developmental Individual-difference Relationship (DIR) model and "Floortime." These therapies are intended to be spontaneous play sessions between a child with autism and an adult. Also, this bill would reduce the required educational levels of autism service paraprofessionals.	**09/05/2018** Sent to the Governor's Desk **08/28/2018** Senate concurred in Assembly amendments **01/29/2018** Passed Senate Floor and ordered to the Assembly **02/15/2017** Introduced	Watch CAHP: Oppose LHPC: Oppose

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2565 Chiu	**Covered California Premium Assistance:** Would require Covered California to offer enhanced premium assistance to individuals between 200 percent and 400 percent FPL who enroll in health care coverage through the Exchange. The enhanced premium assistance would be in addition to the current federal subsidies. According to the bill author, the cost to the state would be $300 million, and would increase financial assistance to approximately 550,000 people enrolled in Covered California. While this bill does not impact Medi-Cal directly, it is of interest to CalOptima because individuals often "churn" between Medi-Cal and the individual market.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/30/2018** Passed Assembly Floor and ordered to the Senate **02/15/2018** Introduced	Watch
SB 171 Hernandez	**Medicaid Managed Care Final Rule ("Mega Reg"):** Implements certain provisions of the Mega Reg by making changes at the state level regarding Medi-Cal managed care plans. Specifically, this bill changes the way public hospitals receive supplemental payments and creates a new, across-the-board Medical Loss Ratio (MLR) standard for Medi-Cal managed care plans. DHCS received federal approval for the new public hospitals directed payment structure, comprised of the Enhanced Payment Program (EPP) and the Quality Incentive Program (QIP), in April 2018.	**10/13/2017** Signed into law	Watch
SB 608 Hernandez	**Hospital Quality Assurance Fee (QAF):** Would modify the QAF to bring it into compliance with CMS Medicaid Managed Care Final Rule requirements. The current language of the bill only reflects a portion of the California Hospital Association's proposal to reform the QAF. DHCS received federal approval for the new Private Hospital Directed Payment (PHDP) structure in March 2018. The new structure begins a 10-year phase out of the current QAF structure and phase in of the PHDP.	**09/01/2017** Held under submission	Watch

CAHP: California Association of Health Plans
LHPC: Local Health Plans of California

Last Updated: September 10, 2018

2018 Federal Legislative Dates

January 3	116th Congress convenes 1st session
March 26–April 9	Spring recess
July 27–September 3	Summer recess
November 6	General Election

2018 State Legislative Dates

January 3	Legislature reconvenes
February 16	Last day for legislation to be introduced
April 27	Last day for policy committees to hear and report bills to fiscal committees
May 11	Last day for policy committees to hear and report non-fiscal bills to the floor
May 25	Last day for fiscal committees to report fiscal bills to the floor
May 29–June1	Floor session only
June 1	Last day to pass bills out of their house of origin
June 5	Statewide Primary Election
June 15	Budget bill must be passed by midnight
June 28	Last day for a legislative measure to qualify for the Nov. 6 General Election ballot
July 6–August 5	Summer recess
August 7	Special Election for CA Senate District 32
August 17	Last day for fiscal committees to report bills to the floor
August 20 – 31	Floor session only
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 6	General Election
November 30	Adjournment *Sine Die* at midnight
December 3	Convening of the 2019-20 session

Sources: 2018 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

Board of Directors Meeting
October 4, 2018

CalOptima Community Outreach Summary — September 2018

Background

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events. CalOptima participates in public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors as indicated pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities, including, but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Resource Fair

On October 25, 2018, Community Relations and Case Management will host the CalOptima Community Resource Fair at CalOptima from 9 a.m. to 12 p.m. The purpose of the event is to increase the knowledge of CalOptima staff and our health network partners of resources available in the community to assist members who need help with meeting basic needs such as housing, food, transportation, employment, utilities assistance, legal aid and child care.

Approximately 35 community partners will be available at the event to share information about their programs and services. Community partners invited include non-profit community-based organizations, county agencies and other service providers.

The resource fair is an excellent educational and networking opportunity. All CalOptima staff and the delegated health networks' case managers, personal care coordinators, social workers, referral specialists, and others who help members connect to community resources are invited to attend. Attendees will also have an opportunity to win several gift baskets.

Back to Agenda

For additional information or questions, please contact Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

Summary of Public Activities

During September 2018, CalOptima participated in 39 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
9/03/18	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting
9/06/18	• Refugee Forum of Orange County
9/07/18	• Covered Orange County General Meeting
9/10/18	• Orange County Veterans and Military Families Collaborative Meeting • Fullerton Collaborative Meeting
9/11/18	• Orange County Strategic Plan for Aging — Social Engagement Committee Meeting • Susan G. Komen Orange County — Unidos Contra el Cancer del Seno Coalition • Buena Clinton Collaborative Neighborhood Coalition Meeting
9/12/18	• Anaheim Homeless Collaborative Meeting • Orange County Homelessness Task Force Meeting
9/13/18	• State Council on Developmental Disabilities Regional Advisory Committee Meeting • Kid Healthy Community Advisory Council Meeting
9/14/18	• Orange County Visitation Council Meeting
9/18/18	• North Orange County Senior Collaborative Meeting • Placentia Community Collaborative Meeting
9/19/18	• Covered Orange County Steering Committee Meeting • Minnie Street Family Resource Center Professional Roundtable • Orange County Promotoras Meeting • La Habra Move More, Eat Healthy Campaign Meeting
9/20/18	• Orange County Children's Partnership Committee • Orange County Women's Health Project Advisory Board Meeting
9/24/18	• Stanton Community Collaborative Meeting
9/25/18	• Orange County Senior Roundtable • Santa Ana Building Healthy Communities

Back to Agenda

9/27/18		• Disability Coalition of Orange County Meeting • Orange County Care Coordination for Kids

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff to Attend	Events/Meetings
9/04/18	1	• Annual Veterans Resource Fair hosted by Saddleback College VETS Program
9/08/18	1 1 2	• Community Emergency Preparedness Event hosted by Girl Scout Troop 3155 • Neuro-oncology Family Education Day hosted by CHOC Children's • Senior Saturday Community Festival hosted by Huntington Beach Council on Aging (Sponsorship Fee: $850 included a quarter page ad in newsletters, company logo on event banner and map, announcement of sponsorship during event, link to company website from city's website for six months, one canopy and a table for resource)
9/09/18	2	• Free Health Fair at Our Lady of La Vang Church hosted by St. Joseph Health
9/15/18	1	• Health and Resource Expo hosted by City of Anaheim Active Older Adult Program
9/16/18	1	• Foster Family Picnic hosted by Orange County Social Services Agency
9/20/18	1	• Annual Health Fair hosted by City of Placentia Senior Center
9/21/18	2	• Annual SoCal Alzheimer's Disease Research Conference hosted by UCI MIND and Alzheimer's Orange County (Registration Fee: $250 included a table for outreach at the event and registration for two staff to attend conference)
9/23/18	3	• Mid-Autumn Children's Festival hosted by Vietnamese American Youth Organization (Sponsorship Fee: $1,000 included acknowledgment during stage program, on-stage recognition with Certificate of Appreciation from organizer, newspaper and radio announcements, logo on event t-shirt, banner placement at festival and a display booth space at good location)
9/28/18	1	• Orange County Substance Abuse Prevention Network hosted by Orange County Department of Education (Registration Fee: $70 included one resource table for outreach)
9/29/18	3	• NAMI Walk hosted by NAMI Orange County (Sponsorship Fee: $1,000 included a resource table for outreach at the event and agency logo on promotional materials) • 13th Annual Free Anaheim Health Fair hosted by City of Anaheim (Sponsorship Fee: $1,000 included company name and link on health fair

Back to Agenda

website, company name and logo on banner, and company name displayed on health fair press releases)

CalOptima organized or convened the following nine community stakeholder events, meetings and presentations:

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
9/04/18	• County Community Service Center Health Seminar — Topic: Emergency Preparedness for Older Adults (Vietnamese)
9/11/18	• CalOptima New Member Orientation (English and Spanish)
9/13/18	• CalOptima Health Education Workshop — Topic: Shape Your Life
9/20/18	• CalOptima Health Education Workshop — Topic: Shape Your Life • CalOptima Health Education Workshop — Topic: Opioids • CalOptima Community Presentation — Topic: Transportation Benefits
9/25/18	• Community Alliances Forum — Topic: Supporting Children with Developmental Disabilities and Their Families
9/27/18	• CalOptima Health Education Workshop — Topic: Shape Your Life • CalOptima New Member Orientation (Chinese, Arabic and Vietnamese)
9/29/18	• PACE 5th Anniversary Event

CalOptima provided zero endorsements for events during this reporting period (e.g., letters of support, program/public activity event with support, or use of name/logo).

Back to Agenda

CalOptima Board of Directors
Community Activities

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.

October

Date and Time	Event Title	Event Type/Audience	Staff/Financial Participation	Location
Monday, 10/1 10am-2pm	+Santa Ana Senior Center Annual International Older Adults Fair	Health/Resource Fair Open to the Public	2 Staff	Santa Ana Senior Center 424 W. Third St. Santa Ana
Monday, 10/1 1-4pm	++OCHCA Mental Health Services Act Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Delhi Center 505 E. Central Ave. Santa Ana
Tuesday, 10/2 9:30-11am	++Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	N/A	Downtown Anaheim Community Center 250 E. Center St. Anaheim
Wednesday, 10/3 9-10:30am	++OC Aging Services Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 10/3 10am-12pm	++Anaheim Human Services Network	Steering Committee Meeting: Open to Collaborative Members	N/A	OC Family Justice Center 150 W. Vermont Anaheim
Wednesday, 10/3 10:30am-12pm	++OC Healthy Aging Initiative	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Thursday, 10/4 9-11am	++Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church

+ Exhibitor/Attendee
++ Meeting Attendee

Back to Agenda

				1855 Orange Olive Rd. Orange
Thursday, 10/4 5-6:30pm	*Health Education Workshops Shape Your Life	Open to the Public Registration required.	N/A	Ponderosa Family Resource Center 320 E. Orangewood Ave. Anaheim
Friday, 10/5 10-11am	++Help Me Grow Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Redhill Ave. Santa Ana
Monday, 10/8 1-2:30pm	+OC Veterans and Military Families Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Monday, 10/8 2:30-3:30pm	++Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 10/9 9-10:30am	++Orange County Strategic Plan for Aging-Social Engagement Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Tuesday, 10/9 12-1pm	++Buena Clinton Neighborhood Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Clinton Youth and Family Center 12661 Sunswept Ave. Garden Grove
Tuesday, 10/9 1-2pm	*CalOptima New Member Orientation *Presentation in English and Spanish*	Community Presentation Open to the public	1 Staff	CalOptima
Wednesday 10/10 10-11am	++Buena Park Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Library 7150 La Palma Ave. Buena Park
Wednesday 10/10 10-11am	*CalOptima New Member Orientation *Presentation in Korean and Farsi*	Community Presentation Open to the public	1 Staff	CalOptima

+ Exhibitor/Attendee
++ Meeting Attendee

Back to Agenda

Wednesday, 10/10 12-1:30pm	++Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Wednesday, 10/10 1:30-3pm	++Health Care Task Force Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	State Council on Developmental Disabilities 2000 E.Fourth St. Santa Ana
Thursday, 10/11 11:30am-12:30pm	++FOCUS Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Magnolia Park Family Resource Center 11402 Magnolia St. Garden Grove
Thursday, 10/11 5-6:30pm	*Health Education Workshops Shape Your Life	Open to the Public Registration required.	N/A	Ponderosa Family Resource Center 320 E. Orangewood Ave. Anaheim
Friday, 10/12 8:30am-2:30pm	+OC Women's Health Project Annual Health Summit	Conference Open to the Public. Registration recommended.	Sponsorship $1,000 2 Staff	UC Irvine 400 Calit2 Building Irvine
Friday, 10/12 9am-12:30pm	+City of Brea Health Fair and Flu Clinic	Health/Resource Fair Open to the Public	2 Staff	Brea Senior Center 500 S. Sievers Ave. Brea
Saturday, 10/13 7am-4pm	+Diocese of Orange County Diocesan Ministries Celebration	Health/Resource Fair Open to the Public	2 Staff	Mater Dei High School 1202 W. Edinger Ave. Santa Ana
Tuesday, 10/16 10-11:30am	++Placentia Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Trinity Center Placentia Presbyterian Church 849 Bradford Ave. Placentia
Wednesday, 10/17 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Minnie Street Family Resource Center 1300 McFadden Ave. Santa Ana

Wednesday, 10/17 1-4pm	++Orange County Promotoras	Steering Committee Meeting: Open to Collaborative Members	N/A	Location Varies
Wednesday,10/17 1:30-3pm	++La Habra Move More, Eat Health Campaign	Steering Committee Meeting: Open to Collaborative Members	N/A	Friends of Family Community Clinic 501 S. Idaho St. La Habra
Thursday, 10/18 8:30-10am	++OC Children's Partnership Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Hall of Administration 10 Civic Center Plaza Santa Ana
Thursday, 10/18 2:30-4:30pm	++OC Women's Health Project Advisory Board Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Thursday, 10/18 5-6:30pm	*Health Education Workshops Shape Your Life	Open to the Public Registration required.	N/A	Ponderosa Family Resource Center 320 E. Orangewood Ave. Anaheim
Saturday, 10/20 9am-12pm	+OASIS Senior Center Senior Health and Resource Fair	Health/Resource Fair Open to the Public	Sponsorship $1,000 2 Staff	Oasis Senior Center 801 Narcissus Ave. Corona del Mar
Saturday, 10/20 11am-1pm	*PACE Health and Wellness Event	Health/Resource Fair Open to the Public	N/A	PACE Center 1330 Garden Grove Blvd. Garden Grove
Monday, 10/22 9-11am	++Community Health Research Exchange	Steering Committee Meeting: Open to Collaborative Members	N/A	Healthy Smiles for Kids 2101 E. Fourth St. Santa Ana
Tuesday, 10/23 7:30-9am	++OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange Senior Center 170 S. Olive Orange
Tuesday, 10/23 7:30-9am	++Santa Ana Building Healthy Communities	Steering Committee Meeting: Open to Collaborative Members	N/A	KidWorks 1902 W. Chestnut Ave. Santa Ana
Wednesday, 10/24 9-11:30am	+Cypress Senior Center Medicare Info Fair	Health/Resource Fair Open to the Public	1 Staff	Cypress Senior Center 9031 Grindlay St. Cypress

Thursday, 10/25 8:30-10am	++Disability Coalition of Orange County	Steering Committee Meeting: Open to Collaborative Members	N/A	Dayle McIntosh Center 501 N. Brookhurst St. Anaheim
Thursday, 10/25 10-11am	*CalOptima New Member Orientation *Presentation in Chinese and Arabic*	Community Presentation Open to the public	1 Staff	CalOptima
Thursday, 10/25 1-3pm	++Orange County Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Red Hill Ave. Santa Ana
Sunday-Monday 10/28-29	+National Assoc. for the Education of Homeless Children and Youth Annual Conference	Conference Open to the Public Registration required.	Registration Fee $250 2 Staff	Hilton Anaheim 777 Convention Way Anaheim